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INCREASING HEALTH INSURANCE COVERAGE FOR THE WORKING UNINSURED

Report to the Division of Health Care Finance and Policy, Massachusetts Executive Office of Health and Human Services

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I. EXECUTIVE SUMMARY

This report compares and evaluates various alternative approaches for improving access to the working uninsured including the Insurance Reimbursement Program (IRP) and the MinnesotaCare program. The report performs two specific activities: 1) a qualitative assessment of alternative subsidy programs for addressing the working uninsured issue; 2) a quantitative estimate of participation rates and cost effectiveness for the IRP compared to the MinnesotaCare program. Taken together, the analysis in this report should assist Massachusetts policy makers in projecting the cost and effectiveness of the IRP, setting participation goals for the program, and determining an evaluation strategy for the program.

Because it is difficult to make definitive recommendations for a "best" approach for Massachusetts to address its working uninsured problem, this study makes a qualitative comparisons of the different types of subsidy approaches that other states have adopted to address the working uninsured issue. The study organizes other state programs into three categories for analysis purposes:

1) Subsidies to enroll in state Medicaid programs (Hawaii and Tennessee)

2) Subsidies to enroll in non-Medicaid state-subsidized programs (Washington state, and Minnesota)

3) Subsidies to buy employer-based or other private insurance (Oregon, New York, and Massachusetts)

This study also describes the results from a quantitative model of the IRP that was built to estimate participation in the program. The participation model primarily relies on data from the Census Bureau's Current Population Survey (CPS) from March 1993 and March 1994 as summarized by the Massachusetts Institute of Social and Economic Research (MISER). The participation model builds on research from the econometric literature to estimate participation in the IRP by currently insured families (group and non-group), uninsured families who have declined employer-based insurance coverage, and uninsured families without access to insurance coverage.

The study has several important limitations including:

1) The report only reviews currently operating direct state subsidy programs under the assumption that market reforms without direct subsidies are unlikely to reduce the number of uninsured significantly.

2) The report only reviews state subsidy programs targeted at adults or families with incomes above 100% of poverty because this is the main target population for the IRP.

3) The study's estimates of participation in the IRP have a high degree of uncertainty because of the complexity of the decisions that individuals and employers will make to participate in the IRP and the lack of state experience with programs like the IRP.

4) The data used for the participation model is more than four years old. To produce more accurate participation estimates this study should be updated with newer data.

A. POLICY GOALS OF THE IRP

Based on interviews with Massachusetts policy makers, there is clearly broad agreement on the intended goals of the Insurance Reimbursement Program. The goals are as follows:

1) Decrease the percent of people in working families without insurance coverage, and, as a result, reduce the demand on the Uncompensated Care Pool.

2) Increase the percent of the Massachusetts population with employer-based coverage

   - Increase the percent of small employers (1-50 employees) that offer comprehensive insurance

   - Increase the percent of employees in small firms who accept offered insurance

There is broad agreement among Massachusetts policy makers that the main obstacle to achieving these goals is the affordability of insurance coverage. Policy makers agreed that the main reason employers do not offer insurance is cost to the employer and the lack of ability of employees to afford their share of the premium. The IRP is designed to address both of these problems by subsidizing employers and employees. In contrast, some other states that have tried to address the working uninsured problem have placed far less emphasis than Massachusetts has on insuring the uninsured through private coverage. Oregon and New York are two states that have recently designed programs to coverage the uninsured through private coverage.

B. CHARACTERISTICS OF THE WORKING UNINSURED IN MASSACHUSETTS

Because total participation rates in the IRP depend on the distribution of insurance coverage in the state, the report analyzes the distribution of insurance coverage, the characteristics of the uninsured, and the specific target population for the IRP.

Massachusetts has a somewhat lower uninsured rate (12.6%) compared to the nation (15.5%). This lower rate is probably explained, in part, by the state's high rate of employer-based coverage, 73.7% compared to the national rate of 66.1% (Holahan, 1997). However, there is some evidence that the state's uninsured rate has risen over the last ten years (EBRI, May 1997).

A large portion of the uninsured have incomes under 200% of poverty (45% of adults, and 66% of children) (MISER analysis of March 1993 and March 1994 CPS). However, the large remaining portion of the uninsured above 200% of poverty (the eligibility threshold for the MassHealth program) suggests that a voluntary subsidy program stopping at this level is not going to lead to near universal coverage. Even more importantly for the IRP, many more adults with incomes between 100 and 200% of the federal poverty line are privately insured than uninsured (over 60% more adults are privately insured than are uninsured) (MISER analysis of March 1993 and March 1994 CPS).

Because of the design of the IRP, it can only be effective at insuring uninsured persons if they are employed and have potential access to employer based coverage. Large portions of uninsured adults under 200% of poverty are employed. Forty percent of uninsured adults under 100% of poverty are employed and about two-thirds of adults between 100% and 200% of poverty are employed (MISER analysis of March 1993 and March 1994 CPS).

The portion of employers who offer insurance coverage varies dramatically by size of employer. Employees in firms with more than fifty employees are about twice as likely as employees in firms with fewer than ten employees to be offered, to be eligible for, and to actually enroll in their own employers' coverage (NEHIS, 1993). This lower rate of offering by small employers seems to translate to higher uninsured rates for employees of small firms. Nearly 20% of Massachusetts workers in firms with fewer than 25 workers were uninsured compared to only 6% in firms with more than 200 workers (Donelan, 1995). As many as 66% of uninsured workers in Massachusetts are employed by small firms (50 and fewer workers) who could be eligible for the IRP (Donelan, 1995).

C. QUALITATIVE COMPARISION OF ALTERNATIVE SUBSIDY APPROACHES

This study made a detailed comparison of state subsidy programs targeted to low-income working families in Massachusetts, Oregon, New York, Hawaii, Tennessee, Washington state, and Minnesota. The case studies for this research are included in Section IX.B.1. Table 8 summarizes the results of these case studies. This study can make several conclusions based on its qualitative analyses.

1) *Relative benefit cost.* The IRP has greater benefit flexibility than other state Medicaid expansion programs, or state-sponsored programs. Some would view this as an advantage because it allows the labor market to determine benefits; others would view this as a disadvantage because it does not ensure that the IRP pays for a very comprehensive benefit package. The state plans to define a minimum benefit package that ensures that all enrollees have good comprehensive coverage.

   The IRP will require the state to pay a much smaller share of each enrollee's insurance premium than Medicaid expansions or other state-sponsored programs do. The IRP will pay about 55% of total insurance costs, whereas other programs pay between 85% and 95%.

2) *Administrative cost.* The IRP's simple income eligibility rules and lack of "fire walls" to avoid crowd out will reduce its administrative cost compared to other state subsidy programs. However, the IRP's complex payment and reconciliation system will increase administrative costs compared to other state programs where people directly enroll in a government program. As a result the IRP's administrative cost will probably be about the same as other state subsidy programs of similar size.

3) *Substitution for private insurance coverage.* Unlike some Medicaid expansions and state-sponsored programs, the IRP avoids the unfairness that "fire-walls" create for low-income people who are already buying insurance. The IRP will probably spend the majority of its funds on people who already have insurance coverage, however, the program will be effective at keeping newly enrolled people in the private insurance market. In this way the IRP will be less effective than other state programs at avoiding paying for people who are already insured, and it will be more effective at not substituting government coverage for private coverage. In addition, unlike Medicaid and state-sponsored programs, the IRP will create smoother transitions between government coverage and private coverage. There is some evidence that some people in Medicaid and state-sponsored programs do not return to private coverage when they can. Because the IRP's enrollees will already be in private coverage, this will not be a problem.

4) *Susceptibility to fraud and gaming.* The IRP creates fewer opportunities for fraud and gaming than some other programs because it uses simple eligibility rules and does not try to verify lack of private coverage. However, it will need to provide adequate administrative funding to oversee its payment systems to detect and correct for any overpayments. DMA's new approach of allowing carriers to verify eligibility before DMA makes payments to carriers might reduce some of the potential for overpayments.

5) *Coordination with other programs.* Despite the complex web of programs that Massachusetts has created for low-income persons, the IRP appears to be very well coordinated with other programs. In many ways Massachusetts is paying more attention to coordination of coverage and transitions between coverage than other states with fewer programs. Probably the most important factor in achieving coordination is strong administrative and systems coordination and the elimination of as many organizational boundaries as possible between programs; all of these factors appear to be present for the IRP.

5) *Political sustainability.* The study did not find any important differences in political sustainability among private subsidy programs (like the IRP), Medicaid expansions, and state-sponsored programs. Each program type has had difficulties finding adequate funding during state fiscal crises. There is some evidence that a dedicated funding source (as is present in Minnesota) can help a state subsidy program sustain itself.

D. COST EFFECTIVENESS AND PARTICIPATION ANALYSIS

The study built a quantitative model to estimate participation in the IRP based on the specific rules and prices in the program. The model calculates participation separately for currently insured persons, uninsured persons who have declined employer coverage, and uninsured persons without access to employer coverage. Because of the great uncertainty in calculating participation in the IRP, the study produces a best estimate, a low participation estimate, and a high participation estimate. The results of the participation model are described in Table 13 and Table 14. The study can make two main conclusions based on the quantitative analysis.

1) *Cost effectiveness.* The IRP is likely to be somewhat more costly for each uninsured enrollee than the MinnesotaCare program has been. Based on this study's best estimate, the IRP will cost $136 per uninsured enrollee (based on an assumed cost of $100 per enrollee), compared to $95 for MinnesotaCare. However, because of the different program rules for MinnesotaCare and the IRP, this might not be a fair comparison. Many enrollees in the IRP would probably be ineligible for MinnesotaCare and vice versa. The IRP is targeting a population where it is very difficult to target government funds efficiently, while MinnesotaCare is targeting the portion of the working uninsured where it is easier to be efficient. It is unclear that MinnesotaCare would be any more efficient than the IRP if it were targeting working people with closer ties to employer-based coverage.

8) *Participation rates.* The IRP will probably reach a smaller portion of its target population than MinnesotaCare. According to this study's best estimate, the IRP will reach 18% of uninsured people under 200% FPL in families with a small business worker. MinnesotaCare reaches about 23% of its target population. However, based on this study's high estimate, the IRP could reach 30% of its target population.

E. CONCLUSIONS AND RECOMMENDATIONS

The main finding of this study is that the IRP will probably be as cost-effective as a state-sponsored insurance approach (like MinnesotaCare) in covering uninsured workers who can't afford their employer's coverage, and in covering workers who have had recent, or are likely soon, to have access to employer-based coverage. MinnesotaCare appears to be more cost-effective than the IRP primarily because it avoids this difficult-to-target group. The IRP will cover its target population through private coverage, and will minimize the disruptions of the private insurance market that some have attributed to Medicaid expansions and state-subsidized programs.

An additional positive feature of the IRP is that it transfers income to low-income workers regardless of whether they currently have insurance coverage. The IRP avoids the unfairness of excluding subsidies from low-income people who have already made the expensive choice to buy insurance coverage. Although the program appears to be less cost-effective than MinnesotaCare in covering currently uninsured persons, the resources that do not go to uninsured persons go to other low-income workers and their families who are equally deserving of income assistance.

It is important to note another limitation of this study. This study has focused its quantitative comparison between the IRP and MinnesotaCare on the programs' reduction in the number of people who are currently uninsured. However, a complete comparison of the two programs should examine the effects on the number of uninsured over a one or two-year period (for example, the number of person-months of uninsurance over a two-year period, rather than the number of uninsured persons at a point in time). The Massachusetts IRP invests the majority of its resources in low-income persons who are already insured under the belief that this subsidy will reduce the likelihood that they will become uninsured at a later time. The MinnesotaCare program insures persons who are without access to insurance while they are enrollees of MinnesotaCare, but the program could discourage employers from beginning to offer insurance to these workers. The potential effects of these two different program designs on the number of uninsured persons over time are subtle, difficult to measure, and beyond the scope of this study. However, these issues are important in the policy discussion on the IRP.

However, Massachusetts could take better advantage of the best of MinnesotaCare and the IRP. The state could improve the cost-effectiveness and participation performance of the IRP if it allowed more individual's who do not have access to employer-based coverage to use their subsidy to buy MassHealth coverage or coverage through the state's reformed non-group insurance market. Already, families with children with incomes below 133% of poverty, and children and pregnant women with incomes below 200% of poverty have this option. This "individual" subsidy option would probably not undermine the goals of the IRP but would permit a group, that will probably continue to be large in number, to buy affordable coverage.

One concern with this individual option is that it might discourage employers from beginning to offer insurance if their employees could be insured directly under MassHealth. The state could address this concern in at least two ways. First, the state could delay implementation of an expanded individual subsidy option until several years after the IRP begins. In this way employers might add coverage because of the IRP, and the program's positive payment for employers to continue their coverage would discourage them from dropping coverage. Second, the state could subsidize insurance in the reformed individual coverage market rather than through MassHealth. Because workers strongly prefer group to individual coverage, an individual market option will probably not discourage employers from offering coverage.

A. WHAT IS THE IRP?

The Massachusetts Insurance Reimbursement Program (IRP) is a subsidy for small employers and their employees to hold employer-based coverage. The program provides two types of subsidies:

1) An annualized payment to small employers (1-50 employees) of $400 for single coverage, $800 for two person coverage, and $1,000 for family coverage for each employee with a family income less than 200% of the federal poverty line (FPL). Small employers are only eligible for this payment if they offer comprehensive coverage and make a contribution of at least 50%. The payment is designed to encourage employers to offer or continue to offer insurance.

2) A subsidy to families to hold employer-based coverage at a small employer.[1] The subsidy is available to families with incomes less than 200% FPL whether or not the family already holds insurance coverage.

These dual subsidies are designed to reduce the number of uninsured persons working for small employers by improving the affordability of insurance coverage for the small employer and its employees.

B. PURPOSE OF THIS REPORT

The report performs two specific activities: 1) a qualitative assessment of alternative subsidy programs for addressing the working uninsured issue; 2) a quantitative estimate of participation rates and cost effectiveness for the IRP compared to the MinnesotaCare program. Taken together, the analysis in this report should assist Massachusetts policy makers in projecting the cost and effectiveness of the IRP, setting participation goals for the program, and determining an evaluation strategy for the program.

1. QUALITATIVE COMPARISON OF ALTERNATIVE SUBSIDY APPROACHES

Because it is difficult to make definitive recommendations for a "best" approach for Massachusetts to address its working uninsured problem, this study attempts to identify the relative strengths and weaknesses of the different types of subsidy approaches that other states have adopted to address the working uninsured issue. Although it is difficult to generalize across states, the study organizes other state programs into three categories for analysis purposes (Lipson et al, 1997 chose similar categories for their analysis):

1) Subsidies to enroll in state Medicaid programs (Hawaii and Tennessee)

2) Subsidies to enroll in non-Medicaid state-subsidized programs (Washington state, and Minnesota)

[1] The Division of Medical Assistance plans to offer similar subsidies to purchase large employer coverage for families with children under 133% of FPL, and for some families with children over 133% FPL.

3) Subsidies to buy employer-based or other private insurance (Oregon, New York, and Massachusetts)

The study will compare these different state programs in terms of target population, benefit package, enrollee premium contributions, purchasing vehicle, marketing, program administration, coordination with private coverage, and coordination with other programs. Each of these features is closely tied to the results of the program. The study discusses these program results in terms of relative cost per enrollee, administrative cost, employer crowd-out, susceptibility to fraud or gaming, coordination with other programs, and political sustainability.

2. PARTICIPATION RATE ESTIMATES

The study takes the following approach to calculate participation rates estimates:

1) Brief review of participation rate experience from other states, analyses or modeling of participation rates by other states and researchers, analyses of the price elasticity of employers for offering coverage, and analyses of price and income elasticity of demand by individuals for coverage;

2) Calculation of upper and lower bound of estimates for participation rates in the IRP by already insured employees (both with group and non-group insurance), uninsured employees who have access to coverage; and uninsured employees who do not have access to coverage; and,

3) Selection of a best estimate of participation rates in the IRP.

III. LIMITATIONS OF THIS REPORT

This report is not a complete review of all potential options for addressing the working uninsured issue, nor is it a comprehensive analysis of alternative subsidy approaches to address the working uninsured problem. The analysis is limited because of time and budget in several important ways.

First, in making comparisons to other states, the report only reviews direct subsidy approaches. All of these programs are currently operating. In limiting the analysis to direct subsidy approaches, the report assumes that indirect approaches such as insurance reform, purchasing alliances, and "bare bones" insurance policies are unlikely to have a large effect on the number of working uninsured persons (Nichols 1997, Jensen 1998, Sloan 1997). Because it is easier to contact and collect information from state policymakers involved in currently operating programs, the study has not reviewed programs that are no longer operating.

Second, the comparison is limited to states with large-scale programs targeted at adults or families with incomes above 100% of poverty. The study has chosen this limitation primarily because the IRP is designed as a method to increase employer-sponsored coverage. The labor force participation rates and rates of access to employer coverage are low for families in poverty (according to EBRI, 1997, only 23% of the non-elderly population under 125% of poverty had a full-year worker, and only 12.8% of the non-elderly population under 100% of poverty were covered by employer-based coverage). As a result, if a state program has not covered adults above 100% of poverty, it is unlikely to have dealt with the private coverage coordination and crowd-out issues that are central to the design of the IRP. Therefore, to make the lessons from other states as useful as possible, the study is limited to states that have targeted adults with incomes greater than 100% of poverty.

Third, the study is limited in the certainty with which it can estimate participation rates in the IRP. This uncertainty comes from the lack of experience in estimating individuals' responses to subsidies for insurance coverage, and from the complexity of the decisions that individuals and employers need to make to take advantage of the IRP. For example, for workers without access to employer-based coverage, participation in the IRP requires two actions: 1) an employer decision to offer coverage; and, 2) an employee decision to enroll in coverage. The employer decision is based on at least two factors: 1) awareness that the program exists; and 2) a decision that the benefits of offering insurance and joining the program outweigh the costs of offering insurance and joining the program. The employee decision is based on an assessment that the costs of insurance coverage and joining the program are worth the benefits of insurance coverage.

Most of the quantitative literature on participation rates focuses on an individual's insurance demand as a function of price and income, or an employer's decision to offer insurance as a function of price. However, estimates for the IRP need to combine the results from the separate literatures on employer and individual decision making. There is some quantitative literature evaluating the participation rates for demonstration projects conducted under the Robert Wood Johnson Foundation's Health Care for the Uninsured Program (HCUP). The HCUP programs are similar to the IRP because they focused both on employer and individual participation. However, these projects were conducted on a smaller scale, under different market rules and conditions, and seven to ten years in the past. The dynamics that caused the HCUP programs to have limited success might be different at this time.

Total participation estimates in the program are also uncertain because they depend on the distribution of income, insurance status, work status, and access to employer-based coverage of the

Massachusetts population. To the extent that there is uncertainty in the distribution of these characteristics, there will be uncertainty in participation rates in this report. The sources that this report uses include both surveys of employers and surveys of individuals. Each of these surveys has uncertainty and this uncertainty is compounded when the separate surveys are combined.

Fourth, to describe current insurance coverage in Massachusetts this study uses, primarily, merged CPS data from the March 1993 and March 1994 surveys (as provided by the Division of Medical Assistance in its budget estimates for the MassHealth 1115 waiver). The most current available data is from March 1996 and March 1997. However, because of the time limitations for this study, it was not possible to analyze the newer CPS data. Therefore, the exact participation numbers included in this study should be updated using analysis of the more current CPS data. However, the participation rate methodology included in this study is designed to be applicable to newer data. The participation rate methodology includes references to how newer data should be used.

IV. POLICY GOALS OF THE INSURANCE REIMBURSEMENT PROGRAM

Based on interviews with Massachusetts policy makers, there is clearly broad agreement on the intended goals of the Insurance Reimbursement Program. Even policy makers who do not agree with the intended goals of the program, are very articulate in explaining the intended goals. The goals are as follows:

1) Decrease the percent of people in working families without insurance coverage, and, as a result, reduce the demand on the Uncompensated Care Pool.

2) Increase the percent of the Massachusetts population with employer-based coverage

   - Increase the percent of small employers (1-50 employees) that offer comprehensive insurance

   - Increase the percent of employees in small firms who accept offered insurance

There is broad agreement among Massachusetts policy makers that the main obstacle to achieving these goals is the affordability of insurance coverage. Policy makers agreed that the main reason employers do not offer insurance is cost to the employer and the lack of ability of employees to afford their share of the premium. The IRP is designed to address both of these problems by subsidizing employers and employees.

A. POLICY GOAL ISSUES: IRP SUPPORTER PERSPECTIVE

These goals are important because they illustrate that Massachusetts has a sophisticated view of the interaction of government health insurance and private health insurance. In the course of reducing the number of uninsured persons, supporters of the IRP approach want to minimize the substitution of public health insurance for private insurance. They are concerned both that employees will turn down employer insurance if they can enroll in government insurance at a lower price, and that individuals will not leave government insurance when they have an opportunity to enroll in employer-based insurance. Supporters of the IRP believe that government policies to prevent employers and individuals from dropping current coverage are both unfair and ineffective. They penalize low-wage small employers who have sacrificed cash wages to afford insurance coverage, and the policies reward small employers that can afford to pay higher wages because they have not offered coverage. In addition, the fluidity of business structure for small employers might make it very difficult to determine whether a particular small employer really has not offered insurance in the past. For example, the small employer that did offer coverage disappears, and a new small employer that does not offer coverage appears.

Supporters of the IRP are concerned that, over time, large public subsidies to working families for government health insurance programs will cause a significant reduction in the number of employers offering insurance (especially in industries with many low-wage workers). This will shift health care expenditures for low-wage workers from the labor market to government budgets, and decrease the affordability of insurance for middle income families who are ineligible for a government subsidy. The result could be little progress in reducing the uninsured rate among low-income workers (workers simply shift from private to public coverage), much higher government budgets for health insurance, and increased uninsured rates among middle income working families (who might lose access to employer-based insurance).

B. POLICY GOAL ISSUES: IRP OPPONENT PERSPECTIVE

Policy makers who have concerns about the IRP also express a complex view of these interactions among public and private insurance markets. However, these opponents come to entirely different conclusions. They are concerned that insurance coverage that is tied to employment is inherently less stable and reliable than insurance coverage that is tied to an individual. They believe that it is a poor use of limited government resources to subsidize employers and individuals that already have insurance coverage, when there are effective policies for preventing crowd-out of insurance coverage. They also expressed concern with financing the IRP from the uncompensated care pool (that serves uninsured or underinsured workers as well as the unemployed) when the IRP might do little to reduce the uninsured rate.

Opponents also explained that for many low-income families, the Medicaid program offers better insurance coverage than many small employers can offer. MassHealth offers a choice of many leading private-sector HMOs, when few small employers can offer a choice of plan. Medicaid has no or only nominal copayment requirements, while small employer plans could require significant deductibles and copayments. Medicaid is a sophisticated managed care purchaser that makes a major effort to protect clients and improve the quality of care, a level of effort that no small employer can match. On the other hand, the stigma of enrolling in Medicaid or receiving Medicaid services might discourage some people from enrolling in Medicaid coverage even when they are eligible. However, the IRP might not be a solution to this stigma problem because applicants will still need to fill out a Massachusetts Medicaid application, even though they will eventually be receiving private insurance coverage.

C. TARGET POPULATIONS OF OTHER STATES' PROGRAMS: THE ROLE OF PUBLIC COVERAGE IN REDUCING THE NUMBER OF UNINSURED

Other states have targeted different populations for their programs. For example, Washington State admits any person willing to pay the program's premiums regardless of whether they are uninsured or have access to employer-based coverage. Washington assumes, in part, that because the Washington Basic Health Plan requires premium cost sharing and service cost sharing that is typical of employer-based plans, few working families with access to employer coverage will find that the BHP is a better deal. The fact that the BHP has a long waiting list for coverage also discourages this substitution.

MinnesotaCare only targets the coverage of workers with no access to employer-based coverage and does not attempt to solve the problem of the affordability of employer-based insurance. MinnesotaCare enforces strict "fire walls" that exclude families with insurance within the last four months or access to employer-based coverage with a greater than 50% employer contribution within the last eighteen months. MinnesotaCare also is less attractive than private insurance coverage because its inpatient benefit is limited to $10,000 per year for childless families above 175% of the poverty line. Policy makers assume that people would choose private coverage if they had affordable access to it. MinnesotaCare provides no assistance to workers who cannot afford their enrollee premium contributions, and it does nothing to encourage movement to employer-based coverage when current MinnesotaCare enrollees have that opportunity.

Oregon's program is targeted at the uninsured with incomes above 100% of poverty, the income threshold for the Oregon Medicaid program. Oregon is very concerned that if it subsidizes coverage for workers above 100% of poverty it will have "crowd out" problems. Oregon, similar to Massachusetts, has adopted an insurance subsidy program for private insurance. However, Oregon is also concerned that employers will decrease their contributions to employee coverage if they are

aware that their employees have access to a government subsidy. Therefore, Oregon is only subsidizing employees, so that employers are less likely to be aware that their employees are receiving a government subsidy.

D. MEASURING SUCCESS AGAINST POLICY GOALS

States with Medicaid expansions or non-Medicaid state-sponsored programs (Minnesota, Washington, Hawaii, and Tennessee) measure the success of their programs in terms of the reduction in the uninsured rate following their program's implementation. Because of the goals of the Massachusetts IRP, policy makers need to measure both changes in the uninsured rate among working families and changes in the rate of employer sponsored coverage. However, many other factors can increase or decrease an employer's rate of offering insurance coverage. For example, employer-offering rates might decrease because health insurance premiums increase, but the IRP might have prevented the rates from decreasing further. On the other hand employer-offering rates might increase, but tight labor markets and stable insurance premiums might explain the increase.

Despite these caveats, the success of the IRP can be assessed by monitoring results from the household surveys being conducted by the Division of Health Care Finance and Policy in early 1998 and the end of 1999. However, because it may take more time to detect the effects of the IRP, the Division could conduct an additional survey in 2001 or 2002. Surveys could help to answer the following questions:

1. Among workers, how many are without insurance coverage?

2. Among workers in small businesses, what percent say that they are offered an employer-based plan?

3. Among workers in small or large businesses, what percent are covered by a plan from their own employer; what percent are covered as a dependent on another employer plan?

4. Have there been changes in the number of (working and non-working families) who say they have used free care (presumably from the uncompensated care pool) during the last year?

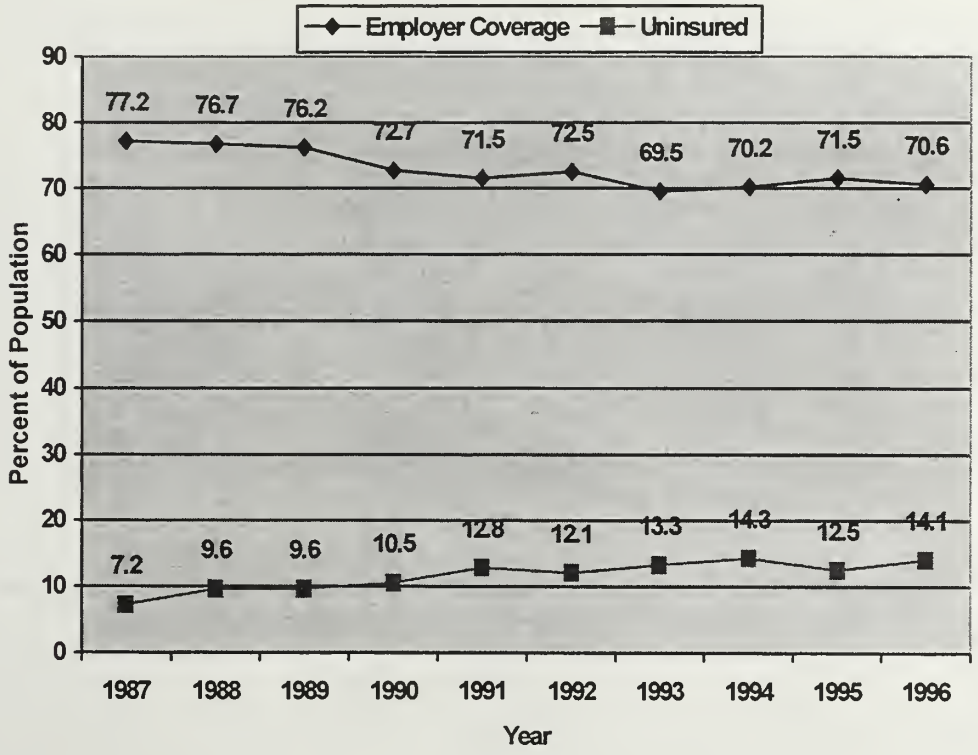
Although improvements in these statistics are not a definitive answer to the success of the IRP, policy makers should look to reversals of trends over time or results that are better than other states with similar economic conditions, labor markets, and personal income. For example, Connecticut is a high-income state with potentially similar economic conditions (although it has lower rate of managed care penetration.) Massachusetts might find that its working uninsured rate decreases after implementation of MassHealth and the IRP, but its employer offering rates and coverage rates remain static. If Connecticut has growing working uninsured rates and static employer coverage, then Massachusetts might decide that it has been successful. Massachusetts should also compare its results to other states like Minnesota that have strong economies but which have not made efforts to shore up employer-based coverage (MinnesotaCare only covers people without access to employer-based coverage).

Because total participation rates in the IRP depend on the distribution of insurance coverage in the state, this section of the report describes the distribution of insurance coverage, the characteristics of the uninsured, and the specific target population for the IRP. The section provides some current information on the total uninsured rate and employer coverage rate in Massachusetts and the trend in these rates. The more detailed statistics in this section are from the merged March 1993 and March 1994 CPS. The Division of Medical Assistance will soon receive an analysis of merged March 1996 and March 1997 CPS data from the Massachusetts Institute of Social and Economic Research (MISER), and should update its participation estimates with this newer data.

A. DISTRIBUTION OF COVERAGE IN MASSACHUSETTS

According to the Urban Institute analysis of the Current Population Survey (CPS), 12.6% of Massachusetts non-elderly population was uninsured in the 1994-1995 period (Holahan, 1997). Massachusetts compares favorably with the national uninsured rate of 15.5% for the non-elderly population. Massachusetts' lower uninsured rate may be explained, in part, by the state's high rate of employer-based coverage, 73.7% compared to the national rate of 66.1% (Holahan, 1997).

Figure 1: Percent of Massachusetts Nonelderly Population with Employer Insurance and without Insurance from 1987 to 1996 (Source: EBRI, May 1997; EBRI, December 1997)



However, there is some evidence that the state's uninsured population has risen in the last ten years. Figure 1 shows the Employee Benefit Research Institute's (EBRI) analysis of the CPS from

March 1988 through March 1997.[2] The figure shows a large decrease in the rate of employer-based coverage and a large increase in the uninsured rate in the 1990-1991 period. This coincides with a major recession in the Massachusetts economy and a period of rapid medical cost inflation. In the early 1990s, the rate of employer-based coverage appears to continue to decline and the uninsured rate appears to continue to increase.[3]

B. CHARACTERISTICS OF THE UNINSURED

1. INCOME

Table 1 shows the distribution of privately insured (employer-based and individual insurance) and uninsured children by income. The vast majority (85%) of privately insured children have incomes above 200% of poverty, the income eligibility limit for the MassHealth program. On the other hand, two-thirds of uninsured children have income below 200% of poverty. Almost half (47%) of uninsured children have incomes under 150% of poverty and, according to DMA's current plans, are eligible for a full subsidy for the MassHealth program.

At first glance, the small percentage (15%) of privately insured individuals with incomes within the MassHealth eligibility limits suggests that "crowd out" should not be a major issue. However, between 100 and 200% of the poverty line, there are more than twice as many children with private insurance as there are without insurance. For any public program focusing on uninsured children between 100 and 200% of poverty it is important to consider the effect on the larger number with private insurance.

Table 1: Distribution of Privately Insured and Uninsured Children in Massachusetts by Income as a Percent of the Federal Poverty Line, 1992-1993 (Source: DMA based on MISER analysis of March 1993 and March 1994 CPS)

	Children 0-18			
	Privately Insured	%	Uninsured	%
0-100% FPL	29,693	3%	39,660	28%
101-133% FPL	20,619	2%	19,856	14%
134-150% FPL	25,188	2%	7,130	5%
151-200% FPL	71,937	7%	27,600	19%
201-400% FPL	435,137	43%	36,700	25%
400% FPL +	434,206	43%	13,146	9%
Total	1,016,781	100%	144,092	100%

Table 2 shows the distribution of adults with private insurance and without insurance. For adults, a much larger proportion of the uninsured have incomes above 200% of poverty (55%),

[2] The EBRI analysis differs in important ways from the Urban Institute analysis cited at the start of this section. EBRI shows a simple calculation of employer-based coverage and the uninsured rate without adjusting for active military members or underreporting of Medicaid enrollment. The Urban Institute statistics are merged for the March 1995 and March 1996 CPS, exclude families with active military members, and use the TRIM2 microsimulation model to adjust for Medicaid underreporting. These differing methodologies probably explain the different statistics from the Urban Institute and EBRI.

[3] Because the March 1996 and March 1997 CPS used different survey questions than in previous years, it is unclear whether the decline in the uninsured rate in 1995 and 1996 was a real decline or a function of the new methodology.

compared to children (34%). Only 26% of uninsured adults have incomes between 100 and 200% of poverty compared to 38% of children. This means that MassHealth's strategy of targeting new government subsidies for children and adults between 100 and 200% of poverty is likely to have a larger effect on the uninsured rate for children than for adults. This conclusion does not imply that it would be a good policy to subsidize adults above 200% of poverty, only that a voluntary subsidy for adults stopping at 200% of poverty is not going to lead to near universal coverage.

Like for children, management of the interaction of public subsidies with private coverage is especially important between 100 and 200% of poverty. The importance of this interaction increases dramatically as family income approaches 200% of poverty. However, even under 100% of poverty, there are 60% as many adults with private coverage as are uninsured.

Table 2: Distribution of Privately Insured and Uninsured Adults by Income as a Percent of the Federal Poverty Line, 1992-1993 (Source: DMA based on MISER analysis of March 1993 and March 1994 CPS)

	Adults 19-64			
	Privately Insured	%	Uninsured	%
0-100% FPL	60,732	2%	97,995	19%
101-133% FPL	51,454	2%	37,635	7%
134-150% FPL	26,573	1%	23,779	5%
151-200% FPL	133,833	5%	69,952	14%
201-400% FPL	962,501	33%	172,742	34%
400% FPL +	1,711,232	58%	106,693	21%
Total	2,946,324	100%	508,796	100%

2. WORK STATUS

Table 3 shows the distribution of labor force participation for adults by income level. This information is important in understanding the opportunities for the IRP to secure employer-based coverage for low-income adults. For the IRP to be effective in insuring a low-income uninsured adult, the adult needs to be employed (or have a spouse who is employed), have an employer who offers coverage, and be eligible for that coverage. Table 3 shows that a substantial number of uninsured adults under poverty are employed (40%). The table shows that the percent of adults with employment increases dramatically above the poverty line and then levels off at about two-thirds. One-quarter of uninsured adults between 100 and 200% of poverty are not in the labor force, however they may have a family member who is in the labor force.

Table 3: Work Status of Uninsured Adults in Massachusetts by Income as a Percent of the Federal Poverty Line, 1992-3 (Source: DMA based on MISER analysis of March 1993 and March 1994 CPS)

	Not in Labor Force	% of row	Unemployed	% of row	Employed	% of row	All uninsured adults
0-100% FPL	41,623	42%	17,371	18%	39,001	40%	97,995
101-133% FPL	9,275	25%	5,338	14%	23,023	61%	37,635
134-150% FPL	5,684	24%	2,048	9%	16,047	67%	23,779
151-200% FPL	16,518	24%	7,709	11%	45,725	65%	69,952
201-400% FPL	36,331	21%	20,173	12%	116,238	67%	172,742
400% FPL +	18,011	17%	10,028	9%	78,654	74%	106,693
Total	127,442	25%	62,667	12%	318,687	63%	508,796

Although approximately two-thirds of workers between 100 and 200% of poverty are employed, many of these workers might not be eligible for employer-based coverage because of length of employment or limited work hours. However, the bulk of uninsured workers work enough to be eligible for employer coverage. According to a Massachusetts population survey conducted in 1995 (Donelan, 1995) for the Department of Medical Security, only 25% of uninsured workers had worked fewer than 6 months with their employer, and only another 15% had worked between 6 and 11 months. The National Employer Health Insurance Survey (NEHIS) conducted in 1993 found that 75% percent of all Massachusetts's employees were eligible for employer-sponsored health benefits.

3. FAMILY STRUCTURE

Unfortunately, neither the information that DMA provided for this study nor the Department of Medical Security study includes tabulations by family structure. Because many of the eligibility rules for the MassHealth and IRP programs are based on family, DMA should consider reviewing population estimates by family structure and income (e.g. working families with children are eligible up to 133% of poverty for MassHealth, but working childless families are only eligible for the IRP). The current budget estimates for MassHealth are based on individuals and not on families, requiring many assumptions to connect children to adults. Analysis of the new CPS data by family structure might permit more accurate estimates of participation rates, and private sector insurance costs.

4. AGE

Table 4 shows the uninsured rate and the distribution of the uninsured by age grouping. The youngest age groups are the most likely to be without insurance coverage.

Table 4: The Uninsured in Massachusetts by Age Group, 1995 (Source: Donelan, 1995)

Age Group	# of individuals	% of state uninsured	% of group uninsured
Under 18	160,000	23	11
18-24	99,000	14	19
25-34	174,000	26	16
35-44	129,000	19	14
45-54	68,000	10	9
55-64	36,000	5	9
65 and above	7,000	1	1

C. EMPLOYER-BASED COVERAGE FOR THE WORKING UNINSURED

This section attempts to measure the employer-based coverage opportunities for the portion of the Massachusetts population that is the target of the IRP. The IRP's target population is workers and their families employed by small employers with family incomes less than 200% FPL.

1. AVAILABILITY BY SIZE OF EMPLOYER

Table 5 shows the percent of employees by firm size who work for an employer who offers coverage, who are eligible for coverage, and who are actually enrolled in coverage. Employees in firms with more than fifty employees are about twice as likely as employees in firms with fewer than ten employees to be offered, to be eligible for, and to actually enroll in their own employers' coverage.

However, the availability of employer-based insurance coverage for employees of small employers is not quite as severe as these statistics might imply. Data from the Medical Expenditure Panel Survey conducted nationally in 1996 shows that employees of small employers frequently have access to coverage through a spouse (Cooper and Schone, 1997). For example, the MEPS analysis finds that 48% of workers in firms with fewer than ten workers were eligible for coverage from their own employer in 1996. However, 63% of these workers were eligible for coverage either from their main job or from another family member's job. In contrast, the family access rate for employees of firms with more than 100 workers was 93%. Although family access ameliorates the access problem for employees of small employers somewhat, it by no means solves the problem.

These statistics illustrate both the opportunity and the challenge for the IRP. There is clearly an opportunity to increase the offering, eligibility, and enrollment rates among employees of small firms (because the rates are so low). However, it is not entirely clear to what extent the IRP subsidies can remove other factors that drive low coverage rates among employees of small firms. Section VII on participation rates provides a quantitative assessment of how effective the IRP might be.

Table 5: Availability of Insurance Coverage to Massachusetts Workers by Firm Size, 1993 (Source: NEHIS, 1993)

Firm Size	% of employees at firms that offer	% of employees eligible for insurance	% of employees enrolled in own employer's plan
Under 10	52.0%	40.1%	30.2%
10-24	83.9%	68.6%	52.4%
Under 50	72.5%	58.6%	43.7%
50 or more	99.1%	82.9%	68.9%
All firm sizes (MA)	90.3%	74.8%	60.5%
All firm sizes (US)	83.1%	67.9%	57.6%

2. UNINSURED WORKERS BY FIRM SIZE

To define the target population by firm size, it is important to define the number of adults by firm size and insurance status. The best information available for this analysis is from the 1995 survey for the Department of Medical Security. Table 6 shows the distribution of firm size of employment for the uninsured and the insured. Nearly 20% of workers in firms with fewer than 25 workers were uninsured compared to only 6% in firms with more than 200 workers.

Uninsured workers in small firms (50 and fewer workers) eligible for the IRP's employer subsidy account for 57% of all uninsured workers. If we assume that workers who did not report a firm size on the survey are distributed across firm sizes in proportion to other uninsured workers, then 66% of uninsured workers work in firms eligible for the IRP.

Table 6: Insured and Uninsured Massachusetts Workers by Size of Firm Where Employed, 1995 (Source: Donelan, 1995)

Firm Size	Insured (%)	Uninsured (%)	% uninsured within firm size
Less than 25	30	49	19
25 to 49	7	8	14
50 to 99	6	6	12
100 to 200	9	6	8
More than 200	40	17	6
Not sure/refused	8	13	17
Total	100		

3. MISSING INFORMATION ABOUT TARGET POPULATION

Unfortunately, the summaries of survey data available for Massachusetts do not count the portion of the population (adults and children), with a worker in a small employer, and with family income under 200% of FPL. In Section VII, the study makes assumptions about the size and characteristics of this population. However, to make more precise estimates, DMA should conduct more detailed analysis of CPS data. The section on participation rates below describes how this information could be used to make more accurate estimates.

VI. QUALITATIVE COMPARISON OF ALTERNATIVE SUBSIDY APPROACHES

The purpose of this section is to review alternatives to the IRP and compare the relative strengths and weaknesses of these programs compared to the IRP. Few states have implemented large-scale programs to enroll the working uninsured above the poverty line. As described in Section VII, this discussion is limited to programs that currently exist and that target uninsured adults above 100% of the federal poverty line. The states that have adopted programs for the working uninsured have followed three general approaches (based on Lipson, 1997):

1) Subsidies to enroll in state Medicaid programs.

2) subsidies to enroll in state-sponsored non-Medicaid programs; and

3) subsidies to buy private insurance coverage.

Three states have implemented Medicaid expansions through 1115 waivers targeted at adults, in addition to pregnant women and children, with incomes above 100% of poverty. These states are Minnesota, Hawaii, and Tennessee. Massachusetts' recent 1115 waiver expansion to families with children with incomes under 133% of poverty also falls into this category, but is not discussed in this study. The 1115 waivers rely on the existing Medicaid eligibility, contracting, and payment infrastructure, although they all require managed care enrollment and deviate from traditional Medicaid in other important ways. This study classifies the MinnesotaCare program in the category of state-sponsored programs (even though this is not a perfect fit) because MinnesotaCare began as a non-Medicaid program and most adult enrollees above 100% of poverty are not included in the provisions of the 1115 waiver.

Two states (in addition to Minnesota) have adopted large-scale state-sponsored non-Medicaid programs. These programs provide individual subsidies for low-income persons to buy coverage through a public purchasing pool of some kind. The Washington Basic Health Plan subsidizes low-income individuals up to 200% of FPL to enroll in a purchasing pool administered by the Washington Health Care Authority that also purchases health benefits for public employees. The New Jersey Health Access Program subsidized individuals up to 250% of the poverty line but stopped accepting enrollment in January 1996. The New Jersey Health Access program is not included in this study because of time constraints. These state-sponsored non-Medicaid programs can build on existing administrative structures without the federal rules that apply to 1115 waivers and without the stigma that some apply to state Medicaid programs.

Three states are currently beginning subsidy programs for private insurance coverage. These approaches differ from the first two categories because they do not directly enroll individuals in public coverage, but instead subsidize the purchase of private coverage under specific conditions. In 1997, New York state began its Health Insurance Partnership Program (HIPP) that subsidizes small employers' purchase of health insurance. In mid-1998, Oregon plans to implement the Family Health Insurance Assistance Program (FHIAP) that will subsidize individuals to buy employer or non-group health insurance. In 1998, Massachusetts plans to implement the IRP. Although the target populations and administrative approaches of these three programs differ, they all are trying to avoid the substitution of public insurance for private insurance by targeting subsidies to the private health care market.

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The review of state programs is broken into two parts:

1) *Description.* Section IX.B.1, describes the state subsidy programs in terms of target population, benefits package, enrollee premium contributions, purchasing vehicle for coverage, marketing, program administration, coordination with private coverage, and coordination among programs. All of these features relate to the programs' effectiveness at reducing uninsured rates and improving health care delivery at the lowest cost to tax payers.

2) *Evaluation.* This section evaluates the strengths and weaknesses of different approaches in terms of relative cost per enrollee, administrative cost, employer crowd-out, susceptibility to fraud or gaming, coordination with other programs, political sustainability, and other qualitative factors affecting participation rates.

This section ends with several tables summarizing the results of the description and evaluation. Descriptions of state programs are based on interviews with and materials provided by state officials. Section 0 lists the names of state officials interviewed.

A. RELATIVE PREMIUM COST

There are at least five ways to assess the relative benefit cost for the different subsidy programs. Table 8 briefly summarizes the results of the relative benefit cost per enrollee analysis.

1) *Relative richness of benefit package.* It is complex to compare prices across state programs and distinguish whether the differences are because of benefits, purchasing aggressiveness, or regional cost differences. Therefore, there is some value in comparing the types of benefits packages that different subsidy approaches imply. Within a particular state, and assuming a constant level of provider reimbursement, a more generous package will be more expensive than a leaner package. This study collected enough information to assess these benefit differences.

2) *Purchasing value.* A program will probably pay less for a defined benefits package if it purchases benefits through a purchasing alliance with aggressive price negotiation and price competition. This study collected information about the purchasing vehicles for different programs.

3) *Actual price of the benefit package.* Although benefit package differences, purchasing differences, and regional cost variations will affect prices, it is still useful to compare the actual full prices that different subsidy approaches pay. This study collected information on full prices for the Medicaid expansions and the state-sponsored programs, but it could not collect information on prices for the private subsidy programs because they are too early in the implementation process.

4) *Cost to the state for each person enrolled in the program.* Even if the full insurance price for a particular subsidy program is high, the cost to the state per enrolled person might be low if the state can take advantage of employer or enrollee contributions. For example, the private insurance purchasing programs might be more expensive because they buy insurance at commercial, rather than discounted Medicaid rates. However, the private insurance purchasing programs take advantage of employer or enrollee contributions, which reduces the cost to the government per enrollee.

5) *Cost to the state for each uninsured person enrolled in the program.* Even if a subsidy program's price per enrollee is low, it could have a very high cost per uninsured person covered, if most enrollment comes from crowding out private insurance coverage. In addition, the Oregon FHIAP and the Massachusetts IRP might cause more employers to offer insurance coverage which will decrease the uninsured rate among individuals who do not receive a premium assistance payment.

1. BENEFIT COMPREHENSIVENESS

There is a clear pattern in benefit comprehensiveness across the different types of subsidy programs. The two Medicaid 1115 waiver programs kept the same or more comprehensive benefits than their original Medicaid programs. The two non-Medicaid programs started with low-end comprehensive packages and have added additional benefits as the programs matured. The private insurance programs generally accept any benefit package in the market (although Massachusetts will have a minimum benefit requirement).

These differences are probably driven by the expectations of the authorizing environment for the different types of programs. Because the Medicaid waivers incorporated all of the original Medicaid population, advocates for current enrollees probably pressured to maintain at least the current level of coverage. The Minnesota and Washington programs were designed originally to extend coverage as far as possible with limited funds. Because the focus was covering people who would not otherwise have any coverage, the states were willing to sacrifice some benefits. This changed over time as the programs developed a client base that needed more benefits. The private insurance programs have the most political flexibility because they are explicitly intended to support private insurance markets. In private insurance markets, price-value trade-offs rather than public decision making processes drive benefits package design.

2. PURCHASING VALUE

Although it is beyond the scope of this study to measure purchasing value in the different types of programs, there is good evidence that large, expert purchasers can purchase a defined set of benefits at a lower price than smaller less informed purchasers. There is strong support for this in the experience of CALPERS, the Washington Health Care Authority (HCA), the Pacific Business Group on Health (PBGH), and some state Medicaid programs (including Massachusetts).

On the other hand, some argue that strong purchasing is less important in reformed insurance markets with guaranteed issue, rate bands, and active marketing rules. Massachusetts, New York, and, to a lesser extent, Oregon all have strong small group and individual insurance reform laws. However, even in these reformed markets it is difficult for a small business, and even more difficult for an individual, to make price-based comparisons among the many different benefit packages and carriers in the market. In addition, few employees in small groups in any of these states have a choice of plan.

Therefore, a strong purchaser that can create an effective managed competition market is more likely to receive a better value. The Medicaid expansions and the state-sponsored programs have the opportunity for strong purchasing (especially the HCA because it also purchases for public employees), and the private insurance subsidy programs do not.

3. PRICE OF BENEFITS

The Medicaid programs appear to be more expensive than the state-subsidized programs. The leaner benefits in the state-subsidized programs probably explain the lower prices for these programs. There is not adequate information to assess the private insurance programs at this time.

4. GOVERNMENT COST SHARE PER ENROLLEE

Based on calculations for this study using state materials, the private insurance subsidy programs have a lower government cost per enrollee (45-85%) than the state-sponsored programs (79-85%) or the Medicaid programs (>95%). These calculations are the portion of the total program paid with government funds divided by the total cost of the program; or, in other words, the average government subsidy per enrollee.

Although the Medicaid expansion programs appear to have a somewhat higher government cost than the state-sponsored programs, this is probably because the Medicaid programs include the traditional Medicaid enrollees who pay no premiums under the 1115 expansions. The BHP and MinnesotaCare only cover the expansion groups beyond traditional Medicaid.

The private insurance subsidy programs have lower per enrollee costs because they take advantage of employer contributions. The New York program will never pay more than 45% of the quarterly premium for an employer. The Massachusetts IRP will pay up to 50% of the total premium on behalf of the enrollee but also pays an employer subsidy (estimated at about 20% of total premium for a single adult). The Oregon program will pay for either employer-based or individual coverage. Because a large portion of the uninsured do not have access to employer-based coverage, the Oregon program has a somewhat higher cost per enrollee.

5. GOVERNMENT COST PER UNINSURED ENROLLEE

Depending on program policies, different programs may be more or less effective at targeting their government funds at currently uninsured people. The more a program insures previously insured people, the higher its cost for covering each uninsured person. Although this is probably the most important measure of a program's effectiveness, it is very difficult to measure. For this reason, the summary table of this study's qualitative evaluation does not include an assessment of government cost per uninsured enrollee.

Some programs have explicit policies to discourage currently insured persons from dropping coverage to join the government program (Tennessee, Minnesota, Oregon, and New York). These states are likely to have lower direct crowd-out where people leave private coverage to enroll in government coverage. However, there can be many kinds of indirect crowd-out that can be significant but difficult to measure. Some employers might not begin to offer coverage, when they would have otherwise, because many of their employees are already covered by government subsidies. Some employees might not have private coverage at the time of enrollment in the government program, but turn down employer coverage later because they are already covered (the "stuck on the government program" phenomenon).

In general the IRP compares very favorably with other state subsidy programs on likely program cost per enrollee. The main uncertainty is how much it will cost Massachusetts for each uninsured

enrollee. The quantitative analysis in Section VII below estimates the relative government costs per uninsured person between MinnesotaCare and the Massachusetts IRP.

B. ADMINISTRATIVE COST

This study was only able to collect administrative cost information for the state-subsidized programs, so it is not possible to make a full comparison across program types. Therefore, the following discussion reviews the qualitative implications for administrative costs of the different programs' design decisions. There are five important factors that drive program administrative costs.

1) *Income only, or assets and income.* A strict asset test can be much more expensive to administer than only an income test. Medicaid programs often have strict asset tests and very few exemptions. All of the subsidy programs reviewed either had no asset test or a very liberal asset test only designed to prevent enrollment by wealthy people.

2) *Exclude private coverage.* To avoid employer crowd-out, many state subsidy programs exclude persons who have current or recent employer-based coverage. Depending on how these rules are administered they can add time and cost to the eligibility determination process because programs need to verify private insurance status. Oregon, Minnesota, New York, and Tennessee have "fire walls" to try to target their program to uninsured people. Hawaii, Washington, and Massachusetts do not have any "fire walls."

3) *Whether to verify and reverify applicant information.* Depending on whether a state has an asset test and excludes private coverage, efforts to verify and regularly reverify information reported on an application can be very expensive. Even though some states are technically supposed to regularly reverify eligibility, they do not have the administrative budgets available to perform this task. Most of the state subsidy programs attempt to do careful verification and reverification, but some have found that the high costs of careful annual reverification are beyond their reach.

4) *Whether to use other program data sources to verify.* The accuracy, timeliness, and cost of income verification can be improved by relying on other already existing databases to verify eligibility information. Two good opportunities for data matching are the use of Department of Revenue (income tax forms) or Department of Labor and Employment (wage reporting) to verify reported income. Because this information was not collected from all states it is not included in the summary table. Massachusetts plans to make extensive use of matches with Department of Revenue data for both outreach and income verification purposes. Hawaii uses data compiled by the state's Department of Labor to verify whether an applicant is eligible for the state's employer mandate. Washington State would like to implement a matching program, but has been unsuccessful up to this point.

5) *Payment process complexity.* The complexity of the payment and payment reconciliation processes is an important administrative cost and administrative risk factor. Not only is a complex payment system expensive to design, administer, and maintain, but it also has a high risk of making mistakes (both large and small).

   One way to measure payment process complexity is to measure the number of

payor/payee relationships in the system. For each payor/payee relationship there is the need for a payment definition process and for a payment verification/reconciliation process. These payor/payee relationships usually involve flows of payments and flows of enrollment information. For example, when a state pays a carrier, the state also tells the carrier which people they are supposed to be covering. When a private insurance subsidy program pays an individual or an employer for private insurance, it needs to collect some information (at some point) about who was actually covered by that payment. In traditional employer-sponsored coverage, there are two payor /payee relationships (one between the employer and the employee for payroll deductions, and one between the employer and the carrier).

Payment systems for subsidy programs are also made more complex if they require relationships with many different carriers. Each relationship with a carrier requires frequent and large volume financial and enrollment transactions. All of the state subsidy programs involve enrolling very large numbers of individuals or employers, but there are big differences among the programs in how many different carriers they work with.

Table 8 shows the number of different types of payee/payor relationships for the different programs and the number of carriers each program works with. In general, it appears that the Massachusetts and New York programs will be more difficult to administer because they are based on eligibility for employer and/or employees, reconciliation of vouchers between carriers and employers, and reconciliation of payments and enrollment between carriers and the state. Although Oregon appears to be using a somewhat simpler approach for private subsidies, the state will need to be sending individual checks to each individual enrollee.

6) *Size of program.* Of course, as program size increases, it is easier to spread fixed administrative costs across a larger base. For smaller subsidy programs, fixed costs are a larger share of total costs than for larger programs. As the BHP grew its administrative costs declined from 14% to 5.5%.

7) *Outreach and marketing effort.* Although outreach and marketing costs are typically a very small part of the budget for any of these state subsidy program, they can be critical for the success of the program. In the initial months of a program, a large fixed outreach budget might appear to be an excessively large share of total program costs. As a result, new subsidy programs tend to under-invest in outreach and marketing.

The Massachusetts IRP compares favorably with other state programs on likely administrative costs in two important ways: it will be using simple rules for eligibility (no asset test or prior coverage test); and, it is building on an existing large eligibility determination system. However, the IRP, like the New York program, is a much more complex payment system and requires many more relationships with carriers. Because payment systems with this level of complexity have not been tried before at this scale, it is not possible to assess whether it will be successful.

C. PRIVATE COVERAGE CROWD-OUT

Specific design aspects of state subsidy programs can contribute to or discourage crowd out. The following discussion describes these features and reviews their presence in each state subsidy program (Henry, 1997). Table 8 summarizes how the states compare on some of these features.

1. FACTORS THAT ENCOURAGE CROWD-OUT

1) *Affordability of public programs.* All of the state subsidy programs discussed in this study are designed to reduce the price of insurance. But, if public coverage is much more affordable than private coverage, both in terms of premium and service cost sharing, it encourages people who are eligible to drop private coverage for public coverage. If a program charges significant premium cost sharing, or service cost sharing it reduces the strength of this incentive.

   Table 8 compares the portion of the total contribution for health insurance that is paid by the state or the employer under each of the state subsidy programs for a single person at 150% of poverty. In 1996, the national average employer contribution to health insurance for an individual was between 76% and 78% depending on the type of plan (EBRI, 1997). The Medicaid and private insurance purchasing programs subsidize premiums at a higher level than the average employer, while the state-sponsored non-Medicaid programs subsidize at a slightly lower level than the average employer. All of the subsidy programs require some level of contribution. The experience of Medicaid and state-sponsored programs is that a very small portion of their enrollment pays significant premiums (only 13% of the BHP enrollment is above 155% of FPL).

2) *Advertising for public programs.* Because it is very difficult to target advertising for public programs just to the people who are uninsured, aggressive advertising campaigns are going to inform both the uninsured and the insured about the availability of government coverage. The study did not collect enough information on state programs to compare them in this area.

3) *No pre-existing condition exclusions in public programs.* Public programs typically have no pre-existing condition exclusions. For some in the individual market or group market, this is an important consideration because the government program can provide them with coverage for an expensive condition much more rapidly than a private program. Table 8 shows that Medicaid and state-sponsored programs do not use pre-existing condition exclusions, but private subsidy programs rely on market decisions. The private subsidy programs should experience the least amount of crowd-out because of this factor.

4) *Ability to stay in government programs even when could get private coverage.* People on the state subsidy program might over time be able to afford private non-group coverage or have access to employer based coverage. However, these people might decide not to leave the government program because it is cheaper, or is more stable coverage (if they leave the government program temporarily it might be difficult to get back in because of waiting lists). This problem is created when states permit people to stay on the state program and pay for the full premium or when a state cannot afford to regularly reverify eligibility for the program.

As Table 8 shows, Minnesota, Tennessee, and Washington permit non-subsidized enrollees to continue in their programs. These states are more likely than the others to have problems with people staying on the government program when they could join private coverage. Minnesota is considering policies to encourage non-subsidized enrollees to buy non-group insurance policies.

5) *Awareness by employers that their workers are subsidized.* This may affect crowd-out in three ways. First, employees might turn down employer based coverage, thus reducing the employers' participation rate and possibly forcing the employer to drop coverage. Second, if an employer is aware that many of their workers could have or do have government assistance for purchasing employer-coverage, the employer could reduce its contribution level to the minimum level required to qualify for the government program and let the government pick up the difference. Third, employers with many low-income workers might be less likely to begin to offer group coverage if a government program already covers many of their workers.

Depending on the way that state programs are administered, employers are more or less likely to be aware that their employees are covered by state subsidy programs. If employees actually need to join a public program to receive subsidies, they may turn down employer coverage at open enrollment time. Because Hawaii, Tennessee, Minnesota, and Washington all require enrollees to join government programs, they risk undermining participation rates in private employer plans. These same states also risk discouraging employers from beginning to offer coverage because the government program may already cover some of their workers. However, this is probably only an issue with employers with a very large concentration of low-wage workers, because the state subsidy programs are now a small part of each state's total health care market.

In comparing the private insurance subsidy programs, a key difference between them is the level of employer involvement. The Oregon program does not plan to inform or rely on employers for any program administration. Therefore, although the Oregon FHIAP subsidies should help support the employer coverage system, they are less likely to cause employers to reduce contributions because employers will probably not know that their employees are receiving subsidies. Because Massachusetts directly relies on employers to administer the subsidy program, there is some chance that employers will reduce their contributions, particularly if the employer can distinguish between high and low-income workers or if the employer mostly hires low-wage workers.

2. FACTORS THAT DISCOURAGE CROWD-OUT

1) *Administrative delays or waiting lists.* Often government programs have waiting lists for coverage or take one to three months to process applications for eligibility. The more complex the eligibility rules, the longer it takes the state to process the application. If a person wants coverage, they can usually buy it much faster in the private market. As the summary table shows, only the BHP now has experience with a waiting list. Even though Washington has no policies that exclude enrollment of people with private coverage options, the waiting list probably discourages people who have affordable private alternatives.

2) *Public program stigma.* Many persons eligible for government low-income subsidy programs have either been on welfare or had a family member on welfare, and they do not want to be on welfare again. For some people, being on Medicaid is like being on welfare. It is difficult to measure the extent of stigma for different types of state subsidy programs because people self-select onto the state programs. The people who sense the most stigma on the state programs, are less likely to join.

   Based on discussions with state policy makers, Medicaid programs are generally considered to have the most stigma, and non-Medicaid programs have lower stigma. On the other hand, because the TennCare program covers so many low-income people who are not on welfare, there is some sense that the level of "Medicaid stigma" has decreased.

   In Washington state, about 10% of the 80,000 BHP children members who are eligible for more comprehensive care at a much lower cost through the BHP+ Medicaid program, choose to pay premiums and stay on the non-Medicaid BHP program.

   In Massachusetts, although the state will be buying private employer coverage, individuals still need to fill out a regular MassHealth application and their employers will be informed that they are eligible for a subsidy. As a result, the Massachusetts program may experience some stigma barrier. In New York, the NYSHIPP program is not income based, so there probably will be a much lower stigma.

3) *"Fire walls" to discourage dropping.* Several of the state subsidy programs have "fire walls" to enroll only currently uninsured persons or people without access to insurance coverage for some time. These policies can be effective at directly avoiding crowd-out (people dropping coverage to join the government program), but are less effective at avoiding indirect crowd-out (people who stay on government programs when they could join private programs, or employers not offering coverage when they otherwise would have).

   Minnesota, Tennessee, New York, and Oregon all have policies that restrict eligibility to people without current coverage, access to affordable coverage, or both. These policies are intended to discourage people from dropping coverage to join the government program or to avoid paying for coverage when an individual could buy on their own.

   Massachusetts is unique among the states that were studied because the state explicitly intends to subsidize employers and individuals that are already insured. In this way the state is paying employers and employees to not dump on the government program.

4) *Buy-in to private coverage.* If a state program is designed to seek out and buy private coverage when it is available, the program might be more successful in avoiding substitution for private insurance. The private insurance programs are explicitly designed to achieve this goal. None of the Medicaid or state-sponsored programs makes any effort to buy private coverage. Oregon requires enrollees to buy

employer coverage when it is available. The Massachusetts subsidy is only available to purchase employer based coverage.

5) *Limited benefits.* If a state program does not offer the comprehensive level of benefits that most people want, it might be considered much less attractive than private insurance coverage, even if it is subsidized. On the other hand, if the state program offers a more comprehensive package than the private market, that could encourage substitution.

   As the summary table shows under the relative premium cost section, there are important benefit differences among states. The Medicaid expansion benefits are very comprehensive and likely to encourage crowd-out, especially for people who need the special benefits that Medicaid offers. The Washington BHP offers mainstream comprehensive coverage and is not likely to encourage crowd-out. MinnesotaCare is likely to discourage crowd-out among higher income childless families because of its limited hospital benefit. The private purchasing programs do not encourage crowd-out by their benefit design.

6) *Non-creditable coverage under HIPAA.* At present, coverage under non-Medicaid public programs is not creditable under HIPAA. Therefore, people leaving programs like the BHP or MinnesotaCare may be exposed to pre-existing condition exclusions as they move into private coverage. This might discourage some people who expect to have health care needs from joining government programs (because they might have a gap in coverage when they return to the private market). It might also force some people to remain on government programs even when they would otherwise leave because they want to keep coverage for an expensive condition. Because the MinnesotaCare and Washington BHP programs are not creditable, they probably discourage some crowd-out, but experience some adverse selection among their non-subsidized enrollees.

In conclusion, the Massachusetts IRP is likely, as its designers intended, to spend a substantial portion of its resources on persons and employers who are already insured. However, because the IRP only purchases private coverage, the program is likely to minimize the substitution of coverage in government programs compared to private programs. Other programs, like MinnesotaCare, appear to have stringent and effective policies to discourage crowd-out, however, these programs do not help people who cannot afford their own employers' insurance coverage. In many important features, the IRP and MinnesotaCare are completely complementary. MinnesotaCare excludes people with access to private coverage, while the IRP only enrolls people with access to employer coverage. The real question is whether the participation rates for the IRP will be high enough among the uninsured population to compensate for the costs of paying for many low-income people who already have insurance coverage. Section VII provides a quantitative comparison of the likely cost-effectiveness of MinnesotaCare and the IRP in covering uninsured workers.

D. SUSCEPTIBILITY TO FRAUD OR GAMING

Each of the state subsidy programs has vulnerabilities to fraud or gaming based on the design of the program. Some of the fraud or gaming opportunities can be addressed through larger administrative investments. State programs help to keep their administrative costs as low as possible, when they reduce incentives for gaming and fraud.

1) *Income and assets.* All of the states except New York rely on an income test to determine eligibility. Depending on a state's administrative resources, the state can make varying levels of effort to verify an applicant's reported income. This study found no evidence that there were any income fraud issues correlated to a specific subsidy approach. Income fraud issues relate more to a state's, or its contractor's, administrative skill and ability to check reported income against other information sources (income tax records, wage files, and payroll records). Because of their concern that people with very high assets, but low incomes, will join the state subsidy programs, some states have implemented limited asset tests.

2) *Private coverage exclusions.* Oregon, Minnesota, Tennessee, and New York all exclude employers or employees who have current or recent access to health care coverage (see summary table under private coverage crowd out). All of these states rely primarily on self-reported information with some checking or auditing of the accuracy of that information. The quality of the self-reported information is probably proportional to the level of effort a state makes to verify the information. Because New York is enrolling small employers and requiring that they not have offered coverage within the last year, the state creates some incentives for gaming. If they have offered coverage within the last year, some small employers might reincorporate under a new name or change their name to receive the state subsidy. Because Massachusetts does not create exclusions for prior coverage it does not have the administrative burden of detecting gaming in this area.

3) *Verification that coverage is purchased.* Because Massachusetts, Oregon and New York all subsidize the private purchase of insurance, they need to collect some verification that the individual or the employer actually purchases the insurance coverage. This is not an issue when the state purchases coverage directly as in Tennessee, Hawaii, Minnesota, and Washington.

   In the case of Oregon, the state will require individuals to send a copy of each month's payroll deduction form before they will make the next payment. For non-group coverage in Oregon, the state plans to collect premiums from enrollees prior to each month's coverage, and pay the insurance plan directly. In Massachusetts, the state plans to verify enrollment in employer-based coverage through monthly computer matches with all carriers insuring small employers. The Massachusetts approach might be very effective if the state is able to administer computer matches with the twenty to forty different carriers serving the small employer market.

4) *Overpayments and recoveries because of eligibility changes during a year.* In all of the state subsidy programs, the states must manage issues of individuals or employers not paying premiums or disenrolling from the program after the state has already made its payments.

   Washington manages this issue by requiring individuals to pay premiums before each month's coverage. They are allowed to pay premiums up to one month late two times during a particular twelve month period; if they pay late more than twice they are disenrolled. If premiums are more than one month late they are disenrolled.

   Oregon, Massachusetts, and New York plan to pay for private coverage in advance

of each month's coverage. However, the employer or employee might decide to drop coverage before that month begins. In this case, the state has overpaid the carrier or the enrollee and needs to recover funds. The private subsidy states could choose to not make their payments until they receive verification of insurance coverage. However, this might create a cash flow hardship for employers and employees. Therefore these states have designed their program so that employers and employees only pay their share of the total premium, but the state is at risk of overpaying. Oregon is at the greatest risk because they could be overpaying and need to collect from individuals. In addition to paying for a month's coverage when an entire employer is not actually enrolled, Massachusetts and New York could overpay when employees leave the job or change status within an employer. To contain the overpayment, Massachusetts and New York need to have methods in place to verify the census each month at each employer.

Massachusetts is beginning to implement an approach that could reduce their susceptibility to overpayment. Carriers in the IRP may choose to verify an individual's eligibility in the program against their own files before they bill the state for the value of an employer's subsidy. In this way, if an individual subsidized employee has left a particular employer, the carrier can detect this before it bills the state for the subsidy for this worker. If the carrier does not make this check before it bills the state, the Massachusetts needs to compare the carrier's eligibility files against the IRP enrollment files and recover any overpayments.

The Massachusetts IRP program creates fewer opportunities for fraud and gaming than some other state programs in terms of the complexity of eligibility determination. The IRP relies only on income checks and does not require an asset or current private coverage or access to coverage test. However, by its nature, the IRP is more vulnerable to fraud in terms of overpayments. The IRP and other private subsidy programs need to fund and design effective systems for checking insurance coverage status each month for their enrollees, and for processing reconciliations for overpayments.

E. COORDINATION WITH OTHER PROGRAMS

As Table 8 shows, the Medicaid and state-sponsored programs made more significant efforts to coordinate with other public programs. However, it is not clear from the research for this study that coordination is a function of program type. Coordination among programs is probably more a function of political and inter-organizational boundaries and barriers.

The Massachusetts IRP program is implementing significant coordination among public programs, and, in fact, might be producing the strongest consistency in an individual's coverage. DMA now administers the MassHealth direct coverage program, and the premium assistance program. The Children's Medical Security Plan (administered by the Department of Public Health) and the MassHealth program share common outreach activities, a common application, a single eligibility determination process, and a single eligibility information system. At first, the myriad of different programs for low-income people in Massachusetts might seem to undermine coordination. However, the consolidation of management in the state's Division of Medical Assistance, and the consistent policy of buying private coverage for the entire family helps to keep the programs together. The differences between the programs is probably more noticeable from a budgeter's perspective than it will be from the client's perspective.

F. POLITICAL SUSTAINABILITY

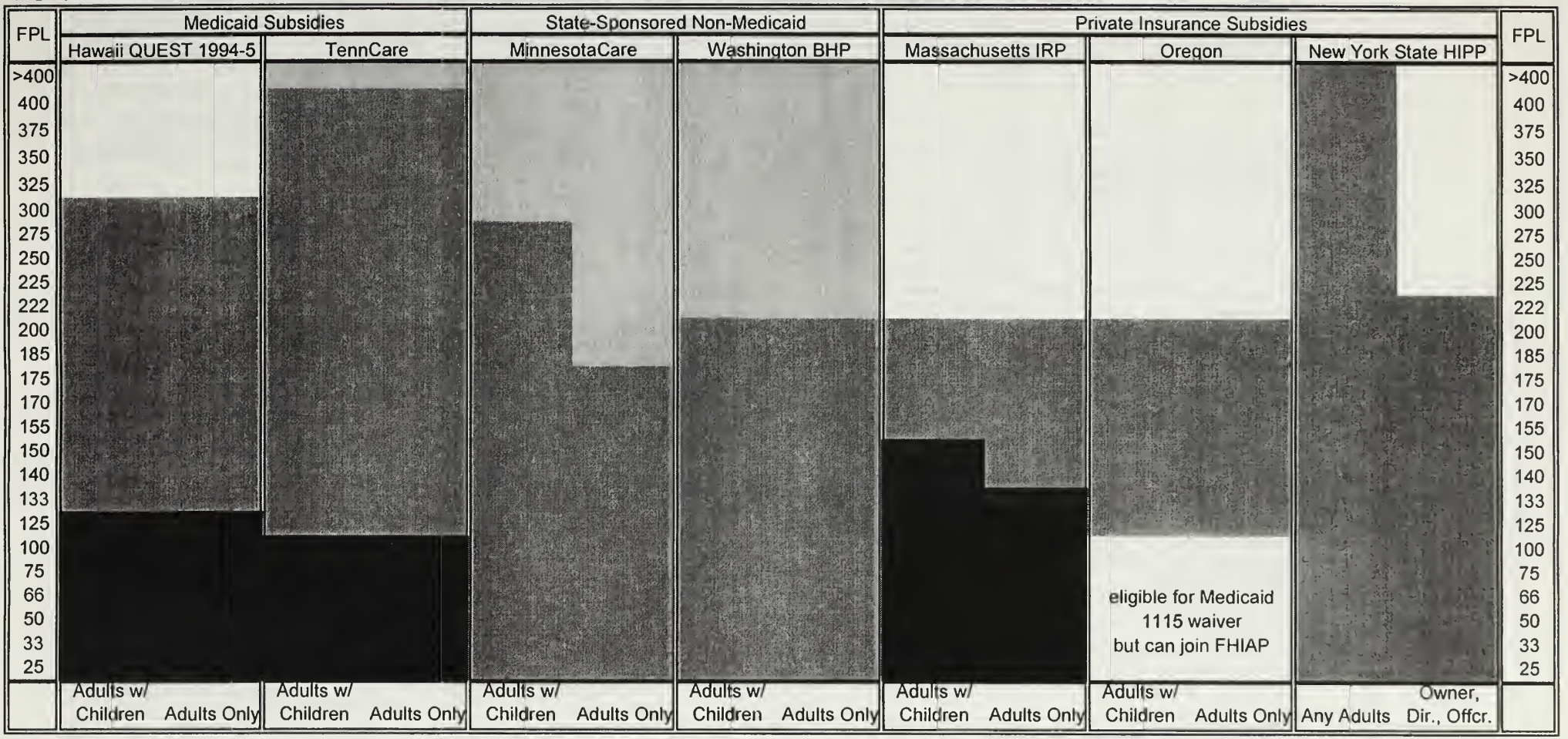
The review of state subsidy programs found no major differences in political sustainability across the different types of programs. Probably the most important factors in a program's sustainability is whether it enrolls a large number of people who then become (along with their providers and insurers) advocates for the program, and whether the state government can afford the program.

All of the different program types studied (Medicaid expansions, state-subsidized programs, private subsidy programs) experienced significant retrenchments, repeals, or caps on enrollment. Many of the private insurance subsidy programs created by states in the late 1980s and early 1990s were either capped or repealed. Maine, Michigan, Wisconsin, and Florida all repealed their employer subsidy programs. New York capped its program in 1993 and did not increase funding until last year. Most of these states cited either budget constraints, changes in the political environment, or low enrollments in closing these programs. It is of course, unclear whether the private subsidy programs would have been capped if they had been more successful in rapidly enrolling large numbers.

The Medicaid expansions in Hawaii and Tennessee reviewed for this study are now completely closed to new enrollment by uninsured adults. Hawaii actually disenrolled all of the adults above 100% of poverty who had joined QUEST. Both Hawaii and Tennessee cite budget limitations in their inability to continue to cover low-income adults above 100% of poverty.

Although the MinnesotaCare program has not experienced significant budget restrictions because it has a strong dedicated funding base, the Washington Basic Health Plan now has 65,400 people on the waiting list with little hope of significant additional funding. The Washington BHP is a good example of the political difficulty of solving the uninsured problem through voluntary state programs. Despite broad bipartisan support for the Basic Health Plan, over 200,000 enrollees, and a ten-year track record of success, it is difficult to gain political support for a significant expansion.

TABLE 7: STATE EXPANSION PROGRAMS FOR ADULTS AGES 18-64 -- ELIGIBILITY LEVEL AND SUBSIDIES



LEGEND

= Eligible with 100% subsidy from state

= Eligible with partial subsidy from state

= Eligible with no subsidy from state

= Not eligible

TABLE 8: STATE EXPANSION PROGRAMS FOR ADULTS AGES 18-64 -- EVALUATION OF SUBSIDY APPROACHES

Evaluation Item	Medicaid Subsidies		State-Sponsored Non-Medicaid		Private Insurance Subsidies		
	Hawaii QUEST 1994-5	TennCare	MinnesotaCare	Washington BHP	Massachusetts IRP	Oregon	New York State HIPP
Relative Premium Cost							
Benefit package	very comprehensive	very comprehensive	comprehensive	comprehensive	moderate	any plan or MSA	an small group plan
Purchaser strength	strong	strong	strong	very strong	weak	weak	weak
Full price for an adult	$171 (August 1995)	$185	$128	$99 (age 19-39) $128 (age 40-54) $218 (age 55-64)	?	?	?
Government cost (state and federal) as % of premium	>95%	>95%	84% (1997)	>85% (adults, June 1997)	55%	<85%	45%
Administrative Cost	?	?	9.5% (1997)	5.5% (1997)	?	?	?
Asset test	none, initially	none	$15,000 with many exemptions	none	none	investment and savings<$10,000	none (generally no income test either)
Check for private coverage or access to private coverage	no	yes	yes	no	no	yes	yes
Verify and reverify self-reported application information	verify and reverify	verify	verify an reverify	verify	verify and reverify	verify and reverify	verify and reverify
Number of different payor/payee relationships	2	2	2	2	4 (state-carrier; state-employee; state-employer; employer-carrier)	2 (state-individual; state carrier)	3 (state-employer; state carrier; carrier-employer)
# of carriers involved	5	11	8	19	>30	4-6	>30
Private Coverage Crowd Out							
Policies that encourage crowd-out							
Government subsidy at 150% FPL for a single adult	93%	87%	70%	67%	90% (employer + state contribution)	90% (employer + state contribution)	>90% (employer + state contribution)
Pre-existing condition exclusions	none	none	none	none	market-based	market-based	market-based
Non-subsidized enrollment	no	yes	yes				
Employer awareness of subsidy program	risk of not offering because low-wage employees covered	risk of not offering because low-wage employees covered	risk of not offering because low-wage employees covered	risk of not offering because low-wage employees covered	employers might reduce contribution to minimum	low risk; employers probably unaware of subsidized workers	low risk; employers cannot join if offered coverage in last year
Policies that discourage crowd-out							
Public program stigma	high	high	medium	medium	medium	low	very low
Waiting lists/administrative delays	none, eligible on date of application	none, eligible on date of application	short delay	long waiting list	no waiting list planned	probably waiting list after program fills up	probably waiting list after program fills up
Exclusions for private coverage	none	initially, uninsured and no access on a fixed date in the past	4 months uninsured; no employer access for 18 months	none	none	6 months uninsured	employer must not have offered coverage for 12 months
Buy private coverage	no	no	no	no	yes	yes	yes
Creditable coverege under HIPPA	yes	yes	no	no	yes	yes	yes
Vulnerability to fraud and gaming							
Income or asset verification	yes	yes	yes	yes	yes	yes	yes
Verifying that private coverage purchased	no	no	no	no	yes	yes	yes
Overpayments issues	risk paying a carrier for extra month (can reconcile after the fact)	risk paying a carrier for extra month (can reconcile after the fact)	risk paying a carrier for extra month (can reconcile after the fact)	risk paying a carrier for extra month (can reconcile after the fact)	risk paying carrier too much (can detect and collect from carrier, carrier collects from employer)	risk paying individual too much (can detect and try to collect from individual)	risk paying carrier too much (can detect and collect from carrier, carrier collects from employer)
Coordination with other state programs							
Coordination activities	Consolitates Medicaid, state subsidized program and General Assistance	Medicaid disenrollee notified about TennCare;	Same health plans for MinnesotaCare and Medicaid; same benefits for families with children	Joint RFP with Medicaid; BHP+ for kids through Medicaid; pregnant women coverage	Single eligiblity system for all MassHealth programs; designed to keep people in priv. plans	People leaving Medicaid will be notified about FHIAP	no coordination found

VII. PARTICIPATION RATE ESTIMATES

A. PARTICIPATION EXPERIENCE FROM RESEARCH AND EXPERIENCE

Several studies have reviewed participation experience in individual and employer subsidy programs. Dr. Leighton Ku of the Urban Institute conducted a careful study of participation during 1995 in the Minnesota, Washington, and Hawaii programs (Ku, 1997). The Alpha Center conducted a review in 1996 of state-subsidized programs for adults and children (Lipson, 1996). Catherine G. McLaughlin and Wendy K. Zellers conducted thorough surveys of small businesses in 1990 to estimate participation in employer subsidy programs at five demonstration sites of the Robert Wood Johnson Foundation's Health Care for the Uninsured Program (McLaughlin and Zellers, 1992). In 1989, Ken Thorpe and colleagues conducted the independent evaluation of the New York State pilot employer subsidy programs that evolved into the NYSHIPP program (Thorpe et al, 1992). In general, each of the studies of individual subsidy programs estimated participation as a percent of all income-eligible uninsured people of the appropriate age. The employer subsidy studies estimated participation as a portion of uninsured businesses in the target size range. Table 9 summarizes the results of these studies. It should be noted that the Washington state program grew by well over 100,000 lives in the year following the Ku study.

Table 9: Participation rates in individual and employer subsidy programs

PROGRAM TYPE AND NAME	PARTICIPATION RATE
Individual Subsidy Programs	
Hawaii QUEST (Ku)	32%
MinnesotaCare (Ku)	26%
TennCare (Lipson)	26%
Washington Basic Health Plan (Ku)	19%
Employer Subsidy Programs	
Tampa, Florida (McLaughlin)	17%
New York State (Thorpe)	4-19%
Flint, Michigan (McLaughlin)	3%

It appears that the individual subsidy programs achieved higher participation rates than the employer subsidy programs. However, the employer subsidy programs analyzed here were pilot projects, were only implemented in limited service areas, and had restrictive administrative rules. In addition, as was discussed above, the employer subsidy programs provide a smaller government subsidy per enrolled person than the individual subsidy programs (because they take advantage of the employer contribution).

Several researchers have also used econometric analysis to estimate the price sensitivity of employers and individuals. The economist's term for price sensitivity is "price elasticity of demand;" or, in other words, the percent change in consumption for each percent change in the price per unit. Marquis and Long, 1995 review the literature on the price elasticity of demand for individual's purchase of insurance and make their own calculations for workers' price elasticity in the non-group market. They estimate elasticities between –0.3 and –0.4 and find that their results are compatible with the previous literature that reported elasticities between –0.16 and –0.54. An elasticity of –0.4 means that a 10% decrease in price will increase the portion of individuals buying insurance by 4% (not percentage points). Chernew et al, 1997 estimated price elasticity for an employed population but found much lower price sensitivity, between –0.033 and –0.095. Chernew's low price sensitivity

was probably because of the already very high participation rate for employees in his study. In the analysis of the IRP that follows, this study assumes an individual price elasticity of –0.4.

Two recent studies have attempted to measure the price elasticity of employers for offering insurance coverage. Both studies use the 1993 RWJ Foundation survey of employers. Feldman, 1997 uses the Minnesota sample from the RWJ survey and calculates a price elasticity of –3.91 for single coverage. Holmer, 1995 uses the full 10 state sample of the RWJ survey and calculates an elasticity of –0.45. Based on the full 10-state survey, a 10 percent reduction in premium will result in a 4.5% increase in the portion of firms offering insurance. Because the Holmer study is based on the full 10-state survey, this study assumes an employer price elasticity of –0.45.

B. PARTICIPATION MODEL FOR IRP

The following discussion reviews the basic steps this study took to estimate participation in the IRP. This study makes no attempt to review or criticize the participation method used by DMA and their consultant William M. Mercer for Massachusetts' budget neutrality submission for the state's 1115 waiver. This study takes a very different approach from that used by the state and concludes with a best estimate of individual enrollment in the IRP of 106,395, at full implementation. The state's estimate is 127,304. The state's estimate is well within the margin of error of this study's estimate, given the complexity of the analysis and uncertainty about the dynamics of a new program.

The basic approach of this study's model is to calculate the participation in the IRP among four groups of workers:

1) workers currently insured by employer-based coverage at a small employer;

2) uninsured small employer workers offered but not accepting coverage at a small employer;

3) small employer workers covered by non-group insurance; and

4) uninsured workers not offered coverage at small employer.

The study estimates participation based on a series of knowledge factors and price elasticities as described below. The study also calculates an upper and lower bound on participation.

The study makes several important simplifying assumptions. First, it assumes that small employer workers currently covered by a spouse's employer will continue to be covered in that manner because the same employee subsidy is available at the other employer (large or small). Second, small employer workers covered by non-group insurance are not offered small employer insurance. In few cases would a worker turn down subsidized employer coverage to buy full-priced non-group coverage. Third, uninsured workers not offered coverage and uninsured workers offered, but not accepting coverage, will enroll in coverage at their own employer and not a spouse's employer.

Fourth, the study assumes that participation by workers can be estimated by applying *employer* participation factors to groups of workers. For example, if the model assumes that 10% more employers of fewer than 10 workers offer insurance, the model will multiply the number of workers who were previously offered insurance by 1.10. This simplifying assumption avoids the need to use a much more complex data set that links workers to their specific employers. This assumption

implies that employers are perfect transmitters of worker desires (which is not true). As a result, this assumption probably causes the model to slightly overstate participation in the IRP.

1. STEP 1: CREATE DISTRIBUTION OF WORKERS BY BUSINESS SIZE AND INCOME

Because existing insurance offer rates vary tremendously within small employers and by employee income, this study first creates a distribution of workers by size of small employer, and family income. The study used the distribution of workers in firms of size 1-9, 10-24, and 25-50 from the National Employer Health Interview Survey data for Massachusetts (Poe, 1997), and normalized that distribution to the total number of workers from the MISER data (Massachusetts CPS for March 1993 and March 1994). Using national CPS data from March and April 1993 (Nichols, 1997), the MISER data, and the Harvard Public Health School survey data (Donelan, 1995), the study estimates the distribution of insured and uninsured workers with incomes below 200% of poverty by small employer size. The study uses national March 1997 CPS data to generate splits among the different types of private insurance coverage (EBRI, 1997). A much better alternative to the data sources used in this study would be to actually calculate this distribution of insured and uninsured workers by income and business size from a three-year merged CPS for Massachusetts (1995, 1996 and 1997). Even with a three-year merged CPS sample for Massachusetts, it may be necessary to collapse some business size or incomes categories.

Table 10 shows the results of this analysis. The 105,653 uninsured workers shown in this table, and their families, are the narrow target population for the IRP. However, the small employer workers already insured by their own employer, another employer, or non-group insurance are also eligible for the IRP if their employer currently offers qualifying coverage or begins to offer qualifying coverage estimated at another 118,813.

Table 10: Assumed distribution of small-employer workers by firm size, income, and insurance status

FIRM SIZE	WORKER INCOME (% FPL)	UNINSURED WORKERS	OWN EMPLOYER INSURED	OTHER EMPLOYER INSURED	NON-GROUP INSURED
<10	<100%	17,330	5,038	4,675	1,851
<10	100-133%	10,230	4,669	4,333	1,716
<10	133-150%	7,130	2,605	2,418	957
<10	150-200%	20,318	14,985	13,906	5,506
11-24	<100%	10,363	3,038	1,582	569
11-24	100-133%	6,118	2,809	1,466	527
11-24	133-150%	4,264	1,568	818	294
11-24	150-200%	12,150	9,016	4,705	1,692
25-50	<100%	5,592	4,380	1,291	395
25-50	100-133%	3,301	4,059	1,196	366
25-50	133-150%	2,301	2,265	667	204
25-50	150-200%	6,556	13,027	3,838	1,176
<50	<200%	105,653	67,453	40,896	15,253

Table 11: Assumptions for calculating participation estimates

	LOW	BEST	HIGH
% of small employers aware of the IRP (author's estimate)	50%	75%	85%
% of small businesses/employees willing to go through enrollment process (author's estimate)	75%	85%	95%
% of small business policies that meet minimum benefit requirement (author's estimate)	80%	90%	95%
Employee price elasticity of demand	-16%	-40%	-64%
Employer price elasticity of demand	-35%	-45%	-55%
Small employer premium (author's estimate from DMA survey data)			
Single	250	180	150
Two-person	500	360	300
Family	600	475	300
IRP subsidy to employers by coverage tier for workers with family incomes <200% FPL			
Single		$400/yr/worker	
Two-person		$800/yr/worker	
Family		$1,000/yr/worker	
Price to childless families enrolled in IRP as % of premium			
Income <100% FPL		0%	
101-133% FPL		0%	
134-150% FPL		10%	
151-200% FPL		15%	
Price to families with children enrolled in IRP ($s/month)			
Income <150% FPL		$0	
151-200% FPL		$10/child ($30 max per family	
% of workers accepting coverage, for workers currently offered coverage (NEHIS, 1993)			
0-9 worker firms		75%	
10-24 worker firms		76%	
25-50 worker firms		72%	
% of workers accepting coverage, for workers not currently offered coverage (Chernew, 1997)		67%	
Distribution of coverage tier for workers (Nichols, 1997 from March, 1993 CPS)			
% of workers needing single coverage		31%	
% of workers needing two-person		31%	
% of workers needing family		38%	
Family size for family coverage tier (author's estimates based on March 1993 CPS)		3.86 people	
% distribution of employer contribution for single/family coverage for currently offering small businesses (RAND Corporation based on 1993 10-state employer survey)			
<50% employer contribution		0%/10%	
50% employer contribution		10%/10%	
75% employer contribution		20%/50%	
80% employer contribution		10%/5%	
90% employer contribution		10%/5%	
100% employer contribution		50%/20%	

2. STEP 2: BUILD TABLE OF ASSUMPTIONS FOR CALCULATING PARTICIPATION RATES

Many detailed assumptions are necessary to calculate participation within each sub-group of workers. Table 11 shows those assumptions. In assumption areas with great uncertainty, the study makes low, best, and high assumptions.

The participation and cost effectiveness results of this study are highly sensitive to its assumptions for small employer awareness, willingness, and benefit eligibility. The small employer awareness and willingness factors assume that there is no option for an individual worker to participate in the IRP directly; a worker's employer needs to agree to enroll in the program and undertake administrative activities before an individual can receive a subsidy. DMA is currently considering options to allow individual workers to receive the employee subsidy even if the employer does not enroll in the program. If DMA implements these options, this study's awareness and willingness factors should be increased in cases where the worker could decide on his or her own to join the IRP.

3. STEP 3: CALCULATE PARTICIPATION FOR DIFFERENT GROUPS

The study separately calculates participation for each sub-group of participants by worker size and income. The sub-groups include: 1) workers insured by own-employer; 2) uninsured workers who offer but decline own employer coverage; 3) workers insured by non-group coverage; and 4) uninsured workers not offered insurance. Participation by sub-groups (1) and (3) does not reduce the number of uninsured; participation by sub-groups (2) and (4) does reduce the number of uninsured. Table 12 shows the study's best estimate of participation by Massachusetts workers in each sub-group by firm size. The following discussion briefly describes the major elements of the algorithm for each subgroup.

Table 12: Best estimate participation of workers in IRP by sub-group of workers

	WORKERS INSURED BY OWN EMPLOYER'S PLAN		UNINSURED WORKERS DECLINING INSURANCE	WORKERS INSURED BY NON-GROUP PLAN	UNINSURED WORKERS NOT OFFERED INSURANCE
FIRM SIZE	RECEIVING EMPLOYER SUBSIDY	RECEIVING EMPLOYEE SUBSIDY (subset of first column)	RECEIVING EMPLOYER AND EMPLOYEE SUBSIDY	RECEIVING EMPLOYER AND EMPLOYEE SUBSIDY	RECEIVING EMPLOYER AND EMPLOYEE SUBSIDY
0-9	14,581	9,553	2,671	1,223	4,772
10-24	8,774	5,748	1,543	415	3,142
25-50	12,676	8,305	2,526	1,601	3,836
all	36,031	23,606	6,741	3,239	11,750

a) Workers insured by own employer's plan

Workers already insured by their employer participate in the IRP by the following algorithm.

IRP participation by own-employer insured workers = (# of own-employer insured workers) X
(% of employers or workers aware of IRP) X
(% of employers willing to enroll) X
(% of employers with qualifying benefits)

This formula assumes that a certain portion of employers will never be aware of the IRP. The assumption used for the best estimate (75% awareness) far exceeds the best results from the heavily advertised RWJ HCUP project in Tampa, Florida where fewer than 50% of employers were aware of the program. The formula also assumes that a subset of employers and employees will not be interested in going through the process of filling out enrollment forms because of the burden of the forms or the stigma of joining a government program. The formula also assumes that some employers will not be offering qualifying benefits. The study assumes that no employers will change their benefits to qualify. Table 12 shows that a somewhat smaller number of employees participate in the program than employers. This is because many employees are already paying the same or lower portion of premium than the IRP requires. The study assumes that employees will not join if they receive no benefit from joining (however their employer could still receive a credit for those employees).

b) Uninsured workers declining insurance from own employer

The algorithm for declining employees is somewhat more complex. Because the IRP requires some cost sharing, some workers who turn down insurance will receive no benefit from the IRP because they already pay the same or less than the IRP requires. The study does not assume any change in employer contributions because of the IRP. The following formula calculates the additional workers who will accept insurance from among the workers who would experience a reduction in their price because of the IRP. The formula has the same elements as for workers who are already insured, except for the addition of price sensitivity factors. Based on the "best estimate" assumptions, a 10% decline in employee price will increase the portion of workers accepting insurance by 4%.

Additional workers accepting insurance = (# of own-employer insured workers) X
(% of employers or workers aware of IRP) X (% of employers willing to enroll) X
(% of employers with qualifying benefits) X
(% price reduction for employee) X (employee price elasticity of demand)

c) Non-group insured and uninsured workers not offered insurance by their own employer

For analytical purposes, the model initially combines the non-group insured and uninsured workers who are not offered insurance by their own employer. This is appropriate because the IRP affects these workers in similar ways, and it is appropriate because the sample sizes in the CPS for non-group insured workers are very small. The study assumes that all employers joining the IRP will offer qualifying benefits. The study uses the following formula for these workers.

Workers accepting newly offered insurance = (# of workers currently offered insurance) X
(% of employers aware of IRP) X (% of employers willing to enroll) X
(% price reduction for employer) X (employer price elasticity of demand) X
(% employee participation for workers not offered) X
(1 + (price reduction for employee from full premium) X (employee price elasticity of demand))

This formula is complex because it includes awareness and willingness factors, employer price sensitivity factors, employee base participation factors for workers who are newly offered insurance (67%), and employee price sensitivity factors. As for previous algorithms, workers are assumed to be a proxy for employers, so that employer factors can be applied to groups of workers. After this formula is applied, the number of newly insured workers is disaggregated into workers who were formerly uninsured and workers who were formerly non-group insured, based on the current distribution of these workers. The model's method for disaggregating these workers probably overstates the number who were previously uninsured because workers with non-group insurance probably have a higher demand for insurance.

d) Conversion of workers to total persons

After calculating the number of workers participating by subscriber tier, the model converts this to the number of persons based on the number of persons in each subscriber tier. This study assumes a family size, for the family tier, of 3.86 persons. This study could be improved by using the distribution of family types and persons per family from a more recent CPS analysis for Massachusetts.

Table 13: Summary results of employee subsidy participation analysis compared to DMA results

	insured covered by IRP	**uninsured covered IRP**	**Total Covered**	**Participation rate (uninsured <200% FPL)**	**Participation rate (uninsured <200% FPL in small businesses)**
Study results					
Low estimate	34,720	14,337	49,056	4%	6%
Best estimate	68,863	46,706	115,568	14%	18%
High estimate	95,384	76,287	171,672	24%	30%
DMA results	62,845	64,459	127,304	20%	25%

Table 14: Comparison of the cost-effectiveness of MinnesotaCare and the IRP

		IRP	MINNESOTACARE
Basic Assumption	Standardized cost per enrollee month	$100	$100
Low estimate	Total enrollment	49,056	64,254 (1995)
	% of total cost paid by government	40.2% (based on model)	84% (1997)
	Govt cost per enrollee	$40.20	$84.00
	% of enrollees previously uninsured	29.2%	86% (1995)
	Standardized cost per uninsured enrollee	$138	$98
	Participation rate (among income, age & business size eligible uninsured)	6%	22%
Best estimate	Total enrollment	115,568	64,254 (1995)
	% of total cost paid by government	55.1% (based on model)	84% (1997)
	Govt cost per enrollee	$55.10	$84.00
	% of enrollees who would be uninsured	40.4%	88% (1995)
	Standardized cost per uninsured enrollee	$136	$95
	Participation rate (among income, age & business size eligible uninsured)	18%	23%
High estimate	Total enrollment	171,672	64,254 (1995)
	% of total cost paid by government	61.4% (based on model)	84% (1997)
	Govt cost per enrollee	$61.40	$84.00
	% of enrollees who would be uninsured	44.4%	92.9% (1995)
	Standardized cost per uninsured enrollee	$138	$98
	Participation rate (among income, age & business size eligible uninsured)	30%	24%
Results based on DMA estimates	Total enrollment	127,304	
	% of total cost paid by government	55.1% (based on model)	
	% of enrollees who would be uninsured	50.6%	
	Standardized cost per uninsured enrollee	$109	
	Participation rate (among income, age & business size eligible uninsured)	25%	

C. RESULTS OF PARTICIPATION ANALYSIS COMPARED TO MINNESOTACARE

Table 13 shows the results of this study's participation model compared to the results from the DMA participation analysis. This study's best estimate is that 46,706 previously uninsured people will participate in the IRP and become insured. DMA estimates that 64,459 previously uninsured people will participate. The DMA estimate is within this study's high participation estimate. Table 13 also shows two different calculations of total participation rates in the IRP. The first shows the uninsured persons covered by the IRP as a portion of all uninsured persons under 200% of FPL in Massachusetts. This method is analogous to how participation rates were calculated for the individual subsidy programs (MinnesotaCare, QUEST, TennCare, and BHP) in Table 9. Compared to individual subsidy programs, the IRP appears to have a somewhat lower participation rate. However, the estimates for individual subsidy programs in Table 9 do not distinguish participation between program enrollees who were previously uninsured and those that were insured. If a crowd-out adjustment of this kind were made, the participation rates in the individual subsidy programs would decrease.

The second participation rate calculates the IRP's uninsured enrollment as a portion of the uninsured under 200% who are in a family with a small employer worker. This is the more specific target population for the IRP. This participation rate method is similar to the one used by McLaughlin and Thorpe in their analyses of participation in employer subsidy programs (see results in Table 9). The best estimate participation rate of 18% for the IRP's narrowly defined target population is very similar to the best results from previous employer subsidy programs.

Although these basic participation rate comparisons are useful, they are not an accurate comparison of the IRP to individual subsidy programs like MinnesotaCare. Two additional factors need to be included to accurately compare MinnesotaCare and the IRP. First, MinnesotaCare's participation needs to be decreased by the number of enrollees who would otherwise be privately insured. Second, one needs to calculate a relative government cost for each uninsured enrollee. Private subsidy programs like the IRP pay a much smaller share of the total insurance cost than individual subsidy programs because they take advantage of employer contributions. Based on this study's model, Massachusetts will pay about 55% of the total insurance costs through the IRP, compared to the 84% that Minnesota pays for MinnesotaCare.

Table 14 compares the two programs by normalizing total program costs to $100 per enrollee, calculating the portion of total insurance cost paid for by each program, and identifying participation of enrollees in each program who would not otherwise be insured. Normalizing program costs to $100 per enrollee eliminates regional cost variation and benefit variation, but also assumes that administrative costs are the same in both programs. The administrative cost assumption is reasonable because both programs coordinate administration with Medicaid and their counties, and they both either try to identify or coordinate with employer-based coverage. Although the MinnesotaCare efforts to exclude people with prior coverage are probably more complex than the IRP's efforts to identify private insurance, the IRP's payment and reconciliation system is more complex than MinnesotaCare's payment system. In addition, by normalizing costs to $100 this study ignores any of the relative value of benefit differences between the programs.

The results show that MinnesotaCare spends considerably less per uninsured person it covers than the IRP is likely to. This study's best estimate is that the IRP will cost $136 per enrollee (assumes $100 per enrollee), and MinnesotaCare spends about $95 per uninsured enrollee. The best estimate predicts that 40% of enrollees would be previously uninsured and that the government would pay 55% of the total insurance costs for all enrollees. This study's high estimate for

participation predicts that a larger share of the IRP's enrollees would have been uninsured (44%) but these additional enrollees are likely to come in with higher government subsidies (the state would pay 61% of total costs). Conversely, this study's low participation estimate predicts that a smaller share of enrollees would have been uninsured (29%) but that the government share of costs would be lower (40% of total insurance costs). Alternatively, using DMA's assumptions, the IRP costs $109 per uninsured enrollee, much closer to the MinnesotaCare figure. MinnesotaCare appears to be more cost-effective than the IRP in covering uninsured persons because the lower crowd-out rate in MinnesotaCare (from the program's severe "fire walls") more than compensates for the program's much higher government share of cost.[4]

MinnesotaCare also appears to reach a larger share of the uninsured than the IRP is likely to. MinnesotaCare reached 23% of age and income eligible uninsured persons compared to the 18% of the age, income, and business-size eligible uninsured that the IRP is likely to reach. However, using this study's high estimate or the DMA estimate, the IRP reaches 25-30% of the eligible uninsured, exceeding the high estimate MinnesotaCare results.

However, in many important ways it is inappropriate to directly compare MinnesotaCare and the IRP. In many respects, the programs are complementary because they target different portions of the working uninsured. MinnesotaCare is limited to workers with no current or recent access to employer-based insurance. The IRP is targeted to workers with current access or with access that the IRP can create with a subsidy. Probably most of the previously uninsured enrollees in the IRP would be ineligible for MinnesotaCare because of current or recent access to employer-based coverage. Many of the enrollees in MinnesotaCare would be ineligible for the IRP because their employers have not and are unlikely to offer insurance coverage. The exception to this general statement is that MassHealth extends direct coverage (as MinnesotaCare does) to families with children up to 133% of FPL and to children and pregnant women up to 200% of FPL.

If MinnesotaCare tried to cover the workers who can't afford employer-based coverage, or the workers with recent access to coverage, it might be less cost-effective than the IRP. For example, if MinnesotaCare started targeting these workers it would probably dramatically decrease the portion of its enrollees who were previously uninsured. According to the MISER CPS data, 54% of the non-Medicaid, nonelderly adults below 200% of poverty currently have private insurance. Assuming that the portion of MinnesotaCare's enrollment consisting of previously uninsured persons declines to 60% from 88%, then MinnesotaCare's normalized cost per uninsured person increases to $140. In this reasonable scenario, MinnesotaCare would be less cost effective than the IRP.

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[4] The variation to produce the low, best, and high participation estimates for MinnesotaCare comes exclusively from varying the assumption on crowd-out for MinnesotaCare. The crowd-out information comes from a 1995 survey of 800 MinnesotaCare enrollees (Lurie, 1995). The high participation estimate crowd-out assumption is based on the fact that 7.1% of MinnesotaCare survey respondants said that they gave up employer-based or individual coverage to join MinnesotaCare (front-end crowd-out). The low particpation assumption is based on the fact that 14% of MinnesotaCare survey respondants said that they are currently insured by employment-based or individual coverage. This indicates that up to 14% of MinnesotaCare enrollees could be covered by private insurance (includes both front-end and back-end crowd-out). The best estimate assumption of 12% is based on the survey response that 12% of MinnesotaCare enrollees reported that it would be "very easy" or "somewhat easy" to afford other insurance besides MinnesotaCare (suggestive of front-end and back-end crowd-out).

VIII. SUMMARY OF CONCLUSIONS AND RECOMMENDATIONS

This study can make several conclusions based on its quantitative and qualitative analyses. Table 8 provides a summary comparison of the IRP to other state programs on qualitative factors, and Table 14 compares the IRP and MinnesotaCare on quantitative factors.

1) *Relative benefit cost.* The IRP has greater benefit flexibility than other state Medicaid expansion programs, or state-sponsored programs. Some would view this as an advantage because it allows the labor market to determine benefits; others would view this as a disadvantage because it does not ensure that the IRP pays for a very comprehensive benefit package. The state plans to define a minimum benefit package that ensures that all enrollees have good comprehensive coverage.

   The IRP will require the state to pay a much smaller share of each enrollee's insurance premium than Medicaid expansions or other state-sponsored programs do. The IRP will pay about 55% of total insurance costs, whereas other programs pay between 85% and 95%.

2) *Administrative cost.* The IRP's simple income eligibility rules and lack of "fire walls" to avoid crowd out will reduce its administrative cost compared to other state subsidy programs. However, the IRP's complex payment and reconciliation system will increase administrative costs compared to other state programs where people directly enroll in a government program. As a result the IRP's administrative cost will probably be about the same as other state subsidy programs of similar size.

3) *Substitution for private insurance coverage.* Unlike some Medicaid expansions and state-sponsored programs, the IRP avoids the unfairness that "fire-walls" create for low-income people who are already buying insurance. The IRP will probably spend the majority of its funds on people who already have insurance coverage, however, the program will be effective at keeping newly enrolled people in the private insurance market. In this way the IRP will be less effective than other state programs at avoiding paying for people who are already insured, and it will be more effective at not substituting government coverage for private coverage. In addition, unlike Medicaid and state-sponsored programs, the IRP will create smoother transitions between government coverage and private coverage. There is some evidence that some people in Medicaid and state-sponsored programs do not return to private coverage when they can. Because the IRP's enrollees will already be in private coverage, this will not be a problem.

4) *Susceptibility to fraud and gaming.* The IRP creates fewer opportunities for fraud and gaming than some other programs because it uses simple eligibility rules and does not try to verify lack of private coverage. However, it will need to provide adequate administrative funding to oversee its payment systems to detect and correct for any overpayments. DMA's new approach of allowing carriers to verify eligibility before DMA makes payments to carriers might reduce some of the potential for overpayments.

5) *Coordination with other programs.* Despite the complex web of programs that Massachusetts has created for low-income persons, the IRP appears to be very well coordinated with other programs. In many ways Massachusetts is paying more attention to coordination of coverage and transitions between coverage than other

states with fewer programs. Probably the most important factor in achieving coordination is strong administrative and systems coordination and the elimination of as many organizational boundaries as possible between programs; all of these factors appear to be present for the IRP.

6) *Political sustainability.* The study did not find any important differences in political sustainability among private subsidy programs (like the IRP), Medicaid expansions, and state-sponsored programs. Each program type has had difficulties finding adequate funding during state fiscal crises. There is some evidence that a dedicated funding source (as is present in Minnesota) can help a state subsidy program sustain itself.

7) *Cost effectiveness.* The IRP is likely to be somewhat more costly for each uninsured enrollee than the MinnesotaCare program has been. Based on this study's best estimate, the IRP will cost $136 per uninsured enrollee (based on an assumed cost of $100 per enrollee), compared to $95 for MinnesotaCare. However, because of the different program rules for MinnesotaCare and the IRP, this might not be a fair comparison. Many enrollees in the IRP would probably be ineligible for MinnesotaCare and vice versa. The IRP is targeting a population where it is very difficult to target government funds efficiently, while MinnesotaCare is targeting the portion of the working uninsured where it is easier to be efficient. It is unclear that MinnesotaCare would be any more efficient than the IRP if it were targeting working people with closer ties to employer-based coverage.

8) *Participation rates.* The IRP will probably reach a somewhat smaller portion of its target population than MinnesotaCare. According to this study's best estimate, the IRP will reach 18% of uninsured people under 200% FPL in families with a small business worker. MinnesotaCare reaches about 23% of its target population. However, based on this study's high estimate, the IRP could reach 30% of its target population.

The main finding of this study is that the IRP will probably be as cost-effective as a state-sponsored insurance approach (like MinnesotaCare) in covering uninsured workers who can't afford their employer's coverage, and in covering workers who have had recent, or are likely soon, to have access to employer-based coverage. MinnesotaCare appears to be more cost-effective than the IRP primarily because it avoids this difficult-to-target group. The IRP will cover its target population through private coverage, and will minimize the disruptions of the private insurance market that some have attributed to Medicaid expansions and state-subsidized programs.

An additional positive feature of the IRP is that it transfers income to low-income workers regardless of whether they currently have insurance coverage. The IRP avoids the unfairness of excluding subsidies from low-income people who have already made the expensive choice to buy insurance coverage. Although the program appears to be less cost-effective than MinnesotaCare in

covering currently uninsured persons, the resources that do not go to uninsured persons go to other low-income workers and their families who are equally deserving of income assistance.[5]

It is important to note another limitation of this study. This study has focused its quantitative comparison between the IRP and MinnesotaCare on the programs' reduction in the number of people who are currently uninsured. However, a complete comparison of the two programs should examine the effects on the number of uninsured over a one or two-year period (for example, the number of person-months of uninsurance over a two-year period, rather than the number of uninsured persons at a point in time). The Massachusetts IRP invests the majority of its resources in low-income persons who are already insured under the belief that this subsidy will reduce the likelihood that they will become uninsured at a later time. The MinnesotaCare program insures persons who are without access to insurance while they are enrollees of MinnesotaCare, but the program could discourage employers from beginning to offer insurance to these workers. The potential effects of these two different program designs on the number of uninsured persons over time are subtle, difficult to measure, and beyond the scope of this study. However, these issues are important in the policy discussion on the IRP.

However, Massachusetts could take better advantage of the best of MinnesotaCare and the IRP. The state could improve the cost-effectiveness and participation performance of the IRP if it allowed more individual's who do not have access to employer-based coverage to use their subsidy to buy MassHealth coverage or coverage through the state's reformed non-group insurance market. Already, families with children with incomes below 133% of poverty, and children and pregnant women with incomes below 200% of poverty have this option. This "individual" subsidy option would probably not undermine the goals of the IRP but would permit a group, that will probably continue to be large in number, to buy affordable coverage.

One concern with this individual option is that it might discourage employers from beginning to offer insurance if their employees could be insured directly under MassHealth. The state could address this concern in at least two ways. First, the state could delay implementation of an expanded individual subsidy option until several years after the IRP begins. In this way employers might add coverage because of the IRP, and the program's positive payment for employers to continue their coverage would discourage them from dropping coverage. Second, the state could subsidize insurance in the reformed individual coverage market rather than through MassHealth. Because workers strongly prefer group to individual coverage, an individual market option will probably not discourage employers from offering coverage.

[5] Some might argue that IRP payments do not go to workers but go to off-set the expenses of employers. However, there is very strong support in the economic literature for the proposition that workers pay for the employer cost of health and other non-cash benefits through lower wages. Although this study does not attempt a review of this literature, there is very strong support for the conclusion that lower employer costs for health benefits will be translated into higher cash wages (although it might be less clear whether the same workers will benefit from the increase in cash wages).

IX. APPENDICES

A. SOURCES

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B. PEOPLE INTERVIEWED

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C. DESCRIPTION OF STATE SUBSIDY PROGRAMS TARGETED AT THE WORKING UNINSURED

1. SUBSIDIES TO ENROLL IN MEDICAID

a) *Hawaii:* QUEST

Hawaii's employer mandate adopted in 1974 required that employers provide health insurance to full-time employees, not including dependents, part-time workers (fewer than 20 hours per week) and the self-employed (Wooldridge, 1996). In 1989, Hawaii created the State Health Insurance Program (SHIP) to cover the gap group of people not covered by the employer-mandate or Medicaid (Wooldridge, 1996). SHIP was available to people under 300% of poverty and charged premiums on a sliding scale. At its end in 1994, SHIP covered about 24,000 people (Wooldridge, 1996).

The QUEST[6] program was started to expand the size of the SHIP program by making the state's Medicaid program more efficient by moving to managed care. The Medicaid waiver was submitted in April 1993, approved in July 1993 and implemented on August 1, 1994. The state hoped that QUEST would be an effective competitive program that would control costs without sacrificing quality.

(1) Target Population

The target population for QUEST was nondisabled persons under age 65 with incomes below 300% of poverty who were not covered by the employer mandate. There were no asset tests from August 1994 to April 1996. By May 1995, QUEST had enrolled over 150,000 people, far in excess of the original projections of 115,000. This increase may have been due to a weak economy at the time, underestimates of the number of uninsured, and better advertising.

Because of this high enrollment, QUEST began charging premiums for families between 101 and 133 percent of poverty in August 1995. By March of 1996, QUEST covered 161,000 people. Because of fiscal pressures and in response to a lawsuit filed by people with disabilities (who were excluded from the demonstration program), the state further restricted eligibility effective April 1996. The state instituted a tight asset test ($2,000 for a single person) and began charging full premiums above 100% of poverty. As a result of the asset test and premium changes, QUEST lost about 31,000 enrollees in May 1996. QUEST now covers about 20,000 more people than it did before the 1115 waiver. According to QUEST program staff, the state cannot now afford to expand eligibility.

[6] QUEST stands for Quality of Care, Universal Access, Efficient Utilization, Stable Cost, Transformation. These were the goals of the program (Wooldridge, 1996).

(2) Benefit Package

The QUEST program covers approximately the same very comprehensive set of services that was covered under Hawaii's former Medicaid program. The program includes nearly all of the allowable optional services for Medicaid with few service limits. Long-term care services are not part of QUEST. QUEST does limit the period of retroactive benefit coverage to the five days before the application date for inpatient and emergency care only (standard Medicaid had offered up to 3 months of retroactive eligibility).

(3) Enrollee Premium Contributions

As described above, enrollee premium contribution requirements increased dramatically over the course of the QUEST demonstration. Between August 1994 and July 1995, only about 5% of the caseload was above 133% and paying any premiums.

Table 15: Enrollee premium contributions for QUEST

INCOME (% FPL)	AUG 94 – JUL 95 PREMIUM %	AUG 94 – JUL 95 $/PERSON/MO.	AUG 95 - MAR 96 PREMIUM %	APR 96 - DEC 97 PREMIUM %	JAN 98 – PREMIUM %
<100%	0%	$0.00	0%	0%	0%
101-133%	0%	$0.00	10%	100%	ineligible
134-200%	5-20%	$8.54 – $34.15	15-50%	100%	ineligible
201-300%	20-100%	$34.15 - 170.76	100%	100%	ineligible

(4) Purchasing Vehicle

A major feature of the QUEST was to institute competitive bidding with HMOs to reduce premium growth rates. The Department of Human Services was responsible for administering the competitive bidding process, contracting with and paying managed care plans, and holding the plans accountable for quality of care.

(5) Marketing

QUEST was very successful in rapidly reaching and enrolling large numbers of previously uninsured people. QUEST hired a public information officer three months before the August 1, 1994 implementation date. The state's marketing goals were to: 1) provide target audiences with QUEST information at least twice; 2) achieve at least a 40% voluntary enrollment rate in managed care plans; and 3) achieve high enrollment rates among uninsured populations. In addition to the public information officer, QUEST spent about $55,000 on marketing.

QUEST notified and informed current and potential clients about the new program through radio, multi-lingual print materials, a multi-lingual customer service line, and outreach through community-base organizations and providers. QUEST made more than 150 presentations before the start of the program to advocacy groups, associations, and medical providers that have regular contact with low-income people. Initially, over 66% of QUEST recipients voluntarily chose a managed care plan. This voluntary choice percentage increased to 90% by April 1995 (Wooldridge, 1996).

(6) Program Administration

Department of Human Services staff carried out all eligibility determination, managed care enrollment functions, and eligibility redetermination functions. QUEST dramatically simplified eligibility determination. First, QUEST staff took over primary responsibility for eligibility determinations from the welfare eligibility staff. Although the welfare eligibility staff does an initial

screen for eligibility, final determination and selection of an MCO is the responsibility of QUEST staff. QUEST staff are fully responsible for non-welfare cases (Wooldridge, 1996). Second, initially QUEST had no asset test, which greatly simplified eligibility determination. Third, soon after the program began, QUEST stationed eligibility workers at FQHCs and hospitals. Fourth, QUEST certified eligibility for welfare cases for 6 months and for non-public cases for one year.

At the start of the program, QUEST did not have adequate numbers of trained eligibility staff, and experienced significant delays in processing applications. This caused some problems because eligibility is retroactive to the date the application is received.

(7) Coordination with Employer-Based and Private Coverage

Unlike any other state, QUEST has very few issues of overlap with employer-based coverage. The test for QUEST eligibility is whether a person is ineligible for the employer mandate (people who work fewer than 20 hours per week, dependents of workers, and self-employed persons). Because of the employer mandate, QUEST staff report that few employers cover more workers than they are required to by the employer mandate. The existence of QUEST to cover workers not covered by the mandate might discourage employers from going beyond the mandate in covering workers or dependents. QUEST verifies eligibility for the employer mandate by checking against state Department of Labor data (the DOL administers the employer mandate).

QUEST staff were concerned that they appeared to be crowding out coverage in the individual market. They sensed that many students were signing up for QUEST rather than joining student insurance programs, and that many lawyers and independent professionals were able to qualify for QUEST by manipulating their income. As a result, soon after implementation, QUEST required students to include their parent's income, if the parent claimed the child as a dependent for tax purposes, and QUEST increased premium contributions to 50% for self-employed persons.

(8) Coordination with Other Programs

QUEST was an explicit effort to consolidate Medicaid, the General Assistance health care program, and the former SHIP program. Now all recipients in QUEST choose from the same managed care plans. Because QUEST covers most people who lose welfare eligibility because their income increases, welfare-level QUEST enrollees are less likely to experience disruptions in their coverage.

b) *Tennessee:* TennCare

In June 1993, Tennessee submitted an 1115 waiver to rapidly move its Medicaid program from fee-for-service to managed care and to dramatically expand coverage to the uninsured with incomes up to 400% of the FPL. "The major objectives of the TennCare program were to provide coverage to uninsured and uninsurable Tennesseans, to fund that coverage through savings in the Medicaid program, and to control Medicaid costs" (Wooldridge, 1996). The waiver was approved in November 1993 and was implemented in January 1994. "In its first 12 months, TennCare increased monthly Medicaid enrollment from 770,000 to more than 1.1 million and transformed Tennessee's Medicaid program from one with only a single, small managed care plan with 35,000 enrollees to one with 12 approved managed are plans that serve the vast majority of enrollees" (Gold, 1995). TennCare is famous for its overnight movement of hundreds of thousands of clients into managed care, but it is also one of the most far-reaching efforts to cover the uninsured attempted by any state.

As of February 1998, TennCare covered 1.23 million people, 837,000 were eligible under pre-TennCare Medicaid rules and an additional 394,000 were uninsured/uninsurable enrollees added through the TennCare expansion.

(1) Target Population

The TennCare expansion was targeted at uninsured persons of any income or family status but premiums were subsidized up to 400% of the federal poverty line. Uninsured and uninsurable enrollees over 400% of poverty pay the full premium. In January 1995, after reaching 90% of its projected enrollment and because of state budget limitations, TennCare closed enrollment to previously uninsured populations, except for uninsurables and people who became uninsured as a result of losing Medicaid eligibility.

In April 1997 TennCare reopened enrollment for previously uninsured children of any income under the age of 18 (as of February 1998, TennCare enrolled an additional 28,000 kids under this provision). In May 1997, TennCare opened enrollment to "dislocated workers" who had lost insurance because of a plant closing. On January 1, 1998, TennCare expanded enrollment for uninsured children to include 18 year olds, and opened enrollment for children under 200% of poverty even if they have access to insurance coverage.

Although the TennCare Bureau intends to redetermine eligibility every 12 months, this has not been done for many of the uninsured enrollees in TennCare. The TennCare Bureau, with the assistance of the Department of Health (the agency that determines eligibility for the TennCare expansion population), is just beginning to send out letters to the uninsured enrollees to begin the redetermination process.

(2) Benefit Package

The benefits coverage under TennCare is very comprehensive and is, in several ways, more comprehensive than previously available under Medicaid. TennCare services include hospital care, physician services, prescription drugs, lab and x-ray services, medical supplies, home health care, hospice care, and ambulance transportation. TennCare added adult inpatient psychiatric services, and eliminated limits on outpatient physician services, inpatient physician services, outpatient visits, home health visits, and prescriptions. Long-term care services are not included in TennCare.

Table 16 shows how coinsurance and deductibles vary by income. Below 100% of poverty there are no deductibles or coinsurance. Above 100% of poverty, deductibles are $250 for an individual adult, $500 per family. However, between 100% and 200% of poverty there are no deductibles for children; above 200% of poverty, children are treated the same as adults. Coinsurance ranges from 2% to 8% for children between 100 and 200% of poverty. Above 200% of poverty, coinsurance is 10% for everyone. Originally, TennCare offered a high deductible plan ($1000 for an individual) to enrollees with incomes above 200% of poverty. This plan was discontinued in February 1996.

(3) Enrollee Premium Contributions

Enrollee premium contributions vary from $0 under 100% of poverty to $185 per month for a single person (full premium) above 400% of poverty. Between 100 and 200% of poverty, these contributions translate to between 8% and 18% of premium for a single person. As the table shows, TennCare's prices for covering a single child above 200% of poverty are expensive compared to private coverage for a single child. It is therefore unlikely that TennCare has enrolled many individual children above 200% of poverty since it reopened enrollment to uninsured children in April 1997.

Table 16: Deductibles, coinsurance, and premiums by income for TennCare, January 1, 1998 (Source: TennCare Bureau)

INCOME (% FPL)	PREMIUMS PER MO.		COINSURANCE		DEDUCTIBLES		
	SINGLE	FAMILY	ADULTS	CHILDREN	INDIVIDUAL	FAMILY	CHILDREN
0-100%	$0.00	$0.00	0%	0%	$0	$0	$0
101-119%	$14.25	$24.50	0%	2%	$250	$500	
120-139%	$17.50	$32.25	4%				
140-169%	$23.50	$47.50	0%				
170-199%	$32.75	$70.50	4%				
200-209%	$73.50	183.50	10%	10%			Same as adult
210-219%	$80.50	$200.75					
220-239%	$87.75	$219.25					
240-269%	$98.75	$246.75					
270-299%	$109.75	$274.00					
300-349%	$128.00	$320.00					
350-399%	$146.00	$365.75					
>400%	$184.75	$461.50					

(4) Purchasing Vehicle

The TennCare Bureau in the Department of Finance and Administration administers the TennCare program. The TennCare Bureau contracts with managed care plans. As of January 1998, TennCare contracted with 11 managed care plans. All core Medicaid and TennCare expansion populations must join one of these plans. As of February 1998, two plans, Blue Cross and Access Med Plus, covered 58% of all TennCare enrollees.

(5) Marketing

Uninsured and uninsurable people apply for TennCare by mail. Applications were widely available at hospitals, doctors' offices, county offices, the TennCare Bureau, local Department of Health offices, and local Department of Human Services offices (Wooldridge, 1996). People receiving food stamps were also mailed an application. Consumers interviewed for a formal evaluation of TennCare reported that they heard about TennCare from many sources including health care providers, television advertisements, local Department of Human Services caseworkers, employer's insurance benefits coordinators, and recruiters for health plans (Wooldridge, 1996).

The simplified application process and broad array of sites that distributed applications probably led to the huge and rapid enrollment of uninsured persons during 1994. By the end of the first year of operations, TennCare program had enrolled 414,408 previously uninsured or uninsurable persons (Wooldridge, 1996).

When TennCare reopened enrollment to uninsured children in 1997, they made significant efforts to find uninsured children including letters to employers, and outreach to day care centers and school nurses.

(6) Program Administration

The TennCare Bureau administered the enrollment of previously uninsured persons and the conversion of nearly 1 million people into managed care plans. The TennCare Bureau contracted with the Farm Bureau (a large insurance company) to verify the insurance status and incomes of the expansion group and to reverify insurance status and incomes one year later to re-establish eligibility (Wooldridge, 1996). This process did not go smoothly and it took the Farm Bureau between 45 and

60 days from application receipt until verification was complete (Wooldridge, 1996). The state comptroller's office found in 1995 that about 10,000 people enrolled in TennCare were ineligible and the eligibility for an additional 262,000 could not be verified (Wooldridge, 1996).

In theory, TennCare redetermines eligibility each year. Each expansion group enrollee receives a letter from the TennCare bureau and must respond within 30 days or lose eligibility (Wooldridge, 1996). Apparently, the Farm Bureau no longer performs the eligibility verification and reverification function; and it is unclear whether Tennessee has ever reverified eligibility information for the uninsured groups. TennCare is now beginning a major effort to redetermine eligibility for the uninsured expansion population. For TennCare's current effort to insure uninsured children, county Health Departments determine income eligibility and verify whether a family has access to private insurance.

Because eligibility began on the date that TennCare received an application, many TennCare enrollees seemed to be unaware of their actual premium cost sharing responsibilities (Wooldridge, 1996). The state had severe problems in collecting insurance premiums from many of these enrollees. In April 1995, the state disenrolled 82,674 expansion group enrollees who had not paid their premiums (Wooldridge, 1996).

During the first year of the TennCare program, the state had numerous problems handling customer volume and modifying eligibility and payment systems to meet the demands of the new program. During the first few days of the program, the hot line was hit with 50,000 calls a day. In the early months, about 250 people staffed the TennCare hot line 12 hours a day, 7 days a week (Wooldridge, 1996)

(7) Coordination with Employer-Based and Private Coverage

The TennCare program's main method for coordinating with private coverage was to exclude enrollees who had access to employer-based coverage. For new enrollment during 1994, TennCare only would enroll people who did not qualify for other health insurance (including employer-sponsored coverage) as of March 1, 1993. Since 1994, the state has not accepted new enrollment of uninsured adults. For TennCare's new effort to insure children, the state excludes children who currently have access to insurance coverage through a parent or guardian.

In general, TennCare staff report that crowd-out of employer-based coverage has not been an important administrative or political concern.

(8) Coordination with Other Programs

The main feature of TennCare's coordination among public programs is the coordination between Medicaid coverage and TennCare expansion coverage. Both core Medicaid and the TennCare expansion use the same managed care plans, so families can keep the same providers as they move between the two programs. As they process applications for TennCare, county health department staff inform families about the availability of Medicaid coverage. In addition, those losing coverage under traditional Medicaid are informed that they have a 30-day period to apply for TennCare; this should decrease the fall off of coverage for low-income people leaving welfare for work (Gold, 1995).

2. SUBSIDIES TO ENROLL IN NON-MEDICAID STATE-SPONSORED PROGRAMS

a) *Minnesota:* MinnesotaCare

MinnesotaCare evolved from an earlier program, the Children's Health Plan (CHP), which began July 1, 1988. The program was originally targeted at children between the ages of one and eight and delivered a limited outpatient benefit package at a price of $25 per child per year. The CHP was the first state-sponsored non-Medicaid program to cover uninsured children. The program was expanded through age 18 and by 1991 it covered 29,000 children.

Landmark health reform legislation adopted in 1992 created MinnesotaCare to incorporate and expand the Children's Health Plan. The plan now included the parents and dependent siblings of children already eligible for MinnesotaCare with incomes below 185% of poverty. In 1993, MinnesotaCare was expanded to cover all families with children under 275% of poverty. In 1994, single adults and married couples without children with incomes below 125% of poverty were added. In 1995, MinnesotaCare was expanded to cover children ages 21 and under, and an 1115 Medicaid waiver was authorized to use federal funding to give MinnesotaCare pregnant women and children a comprehensive benefit coverage. Effective July 1, 1997 the income limit for singles and married couples without children was increased to 175% of poverty. As of January 1, 1998, MinnesotaCare covered 101,450 Minnesotans.

Although MinnesotaCare is partially funded through an 1115 waiver and is now managed in close coordination with Medicaid within the Department of Human Services, all of the non-pregnant adults on the program are covered with state-only funds.

(1) Target Population

The current target population for MinnesotaCare is low-income uninsured families with children and childless families who do not have access to employer based coverage. The target population for the program has been gradually expanded during the 1990s. Families with children are covered up to 275% of poverty; childless families are covered up to 175% of poverty. In 1997, the program added a minimal asset test of $30,000 for a two-person household. MinnesotaCare requires applicants to be uninsured for four months prior to applying for coverage and without access to employer-based coverage with at least a 50% contribution for at least 18 months prior to application.

MinnesotaCare is primarily serving low-income working families without access to employer-based coverage. A 1996 study by the Department of Human Services found that 90% of MinnesotaCare families had at least one working adult.

(2) Benefit Package

Children under age 21 and pregnant women receive the full Medical Assistance benefit set, but adults receive a package with more limitations and copayments. For adults in families above 175% of poverty or in childless families, the inpatient benefits are limited to $10,000 per year, with a 10% copayment (up to $1,000 per year per adult). For adults in families below 175% of poverty, there is no limit on inpatient care but there is a 10% copayment for inpatient services (up to $1,000 a year per adult). Other limitations for adults include:

- only preventive dental care,
- no case management,

- no non-emergency transportation, and
- no personal care attendant services.

However, effective July 1, 1998 adults under 175% of poverty will have access to non-preventive dental care with 50% coinsurance. The limited benefit package for adults already includes mental health care, prescription drugs (with a $3 copayment), alcohol and drug abuse treatment, eyeglasses, and preventive dental care.

Therefore, although there are some limitations on inpatient care for adults above 175% of poverty, even the limited MinnesotaCare package is rather comprehensive.

(3) Enrollee Premium Contributions

For FY 1998, the maximum monthly MinnesotaCare premium is $128 for one person, $255 for two persons, and $383 for three or more persons. Children in families with income less than 150% of poverty pay $4 per month per child. Other persons pay according to a complex sliding scale that is set in state statute. The statute sets premiums at between 1.5% of family income for the lowest income eligibles and 8.8% of income for the highest income eligibles. Families without children must pay the full premium above 175% of poverty. Families with children pay the full premium above 275% of poverty. As a result of this percent of family income approach, family premiums vary based on household income, household size, and the number of members covered. Table 17 shows the family premiums as a percent of the full premium based on family income for a family of four with three or four persons covered by MinnesotaCare.

Table 17: MinnesotaCare premiums for a family of four with three or four persons covered as a percent of the total premium, FY 1998 (Source: DHS, 1998)

INCOME (% OF POVERTY)	FAMILY SHARE OF TOTAL PREMIUM
50%	4%
100%	8%
100%	20%
200%	41%
250%	77%
259%	100%

(4) Purchasing Vehicle

Since January 1997, all MinnesotaCare enrollees were receiving their services through managed care plans purchased by the Department of Human Services. MinnesotaCare and Medicaid managed care purchasing and oversight is coordinated within the Department of Human Services. Although most of the adults in MinnesotaCare are covered with state-only funds, the managed care purchasing for MinnesotaCare is closely coordinated with Medicaid purchasing.

(5) Marketing

Since its creation in 1992, MinnesotaCare has been aggressively marketed. The approach relied on direct mailings, press releases, and presentations to community and civic groups. Marketing efforts were also focused on provider groups, counties, and health fairs. MinnesotaCare also uses a toll-free number of inform callers about the program (DHS, 1998). The marketing initiatives appear

to have been very effective. By October 1993, one year after adults in families with children were eligible, over 22,000 adults were enrolled in MinnesotaCare (DHS, 1998).

A 1995 survey of MinnesotaCare enrollees asked about sources of information about MinnesotaCare. The survey found that 29% of enrollees heard about MinnesotaCare from a friend; 21% from a social worker; 21% from ads; 13% from a doctor, clinic or hospital; and 14% from a dentist or school nurse. These results suggest that building a network of knowledge in local communities about MinnesotaCare was an important part of its success at building enrollment.

(6) Program Administration

The MinnesotaCare program is administered by the Department of Human Services. With the implementation of the 1115 waiver in 1995, the Department has sought to integrate functions between MinnesotaCare and Medicaid. Enrollees apply for MinnesotaCare by mail. State Department of Human Services (DHS) staff process applications, and determine eligibility. Applicants are determined eligible based on income, state residency, and lack of access to health insurance coverage (DHS, 1998). Eligibility is redetermined after one year based on the same factors. A change in household composition or income level could result in an adjusted premium (DHS, 1998). In addition, DHS performs random audits to verify reported income and eligibility (current insurance status is self-reported on the MinnesotaCare application).

(7) Coordination with Employer-Based and Private Coverage

MinnesotaCare is explicitly designed only to cover uninsured groups without recent insurance coverage and without access to affordable employer-based coverage. To be eligible for MinnesotaCare, an applicant cannot have other health care coverage or have had other health coverage for four months before enrollment in MinnesotaCare. Children under age 21 whose family income is at or below 150% of poverty and persons coming off of Medicaid are exempted from this requirement. In addition, applicants cannot have had access to employer-based coverage with at least a 50% employer contribution within the last 18 months. There are exemptions from the past access to employer-based coverage restriction for children under age 21, dependents who lost coverage due to divorce from or death of a policyholder, persons who lost their job due to a lay-off, persons ages 21 to 25 coming off of a parent's policy, or persons leaving military service who were covered by CHAMPUS.

Because of the restrictions on access to employer-based coverage, MinnesotaCare makes no efforts to purchase private or employer-based coverage for recipients. In addition, MinnesotaCare is not designed (with the exception of children) to cover people who cannot afford employer-based coverage when it is offered with at least a 50% contribution. It is interesting to note that virtually all persons in Massachusetts who would be eligible for the IRP would be ineligible for MinnesotaCare, and vice versa.

(8) Coordination with Other Programs

Minnesota's 1115 waiver was designed to integrate MinnesotaCare and Medicaid coverage so that low-income persons would receive seamless coverage as they moved between the programs. MinnesotaCare and Medicaid contract with the same health plans (although not all Medicaid enrollees are enrolled in managed care at this time). For families with children, Medicaid benefits and MinnesotaCare benefits are the same.

b) *Washington:* Washington Basic Health Plan

The Basic Health Plan (BHP) began in 1988 as a five year demonstration in fourteen (of thirty-nine) Washington counties. The program provided sliding scale subsidies for comprehensive

benefits for Washington residents under 200% of the federal poverty line. In December 1992 enrollment reached 22,000 in fourteen counties (Christenson, 1997). In 1993, the legislature approved statewide enrollment, non-subsidized enrollment, and a prescription drug benefit (Christenson, 1997). The BHP is not an entitlement and enrollment is limited by the state budget. In July 1997, the program covered 219,000 state residents through 19 different health plans. On December 20, 1997, there were approximately 65,400 people on the waiting list for subsidized coverage.

(1) Target Population

BHP is targeted to Washington residents under 200% of the federal poverty line. Persons above 200% of poverty can buy into the program at full cost. Coverage is available to children at no cost to the family. Coverage is open to state residents not eligible for Medicare.

(2) Benefit Package

For all enrollees, BHP covers comprehensive benefits except for vision and dental. Subsidized enrollees (under 200% of poverty), have lower cost sharing than non-subsidized enrollees. Table 18 shows the major benefits and cost sharing for the BHP. Children through age 18 are eligible for the BHP Plus program through Medicaid. These children stay in the same health plans as for regular BHP coverage but they receive full Medicaid benefits including no copayments, and vision and dental benefits. BHP+ is partially supported by federal Medicaid funds through a waiver.

Table 18: Basic Health Plan benefits and service cost sharing, 1998 (Source: Christenson, 1997)

SERVICE	SUBSIDIZED ENROLLEES (INCOME < 200% FPL)	NON-SUBSIDIZED ENROLLES (INCOME > 200% FPL)
Office Visit	$8	$10
Hospital	$50	$100
Emergency care	$50	$100
Ambulance	$25	$50
Prescriptions		
Tier 1 (frequently used)	$1	$3
Tier 2 (generics)	$5	$10
Tier 3 (non-generics)	50%	50%

(3) Enrollee Premium Contributions

Family premium contributions vary based on income as a percent of the federal poverty line, age, and the health plan an individual chooses. The overall BHP premiums also vary by age. All children through age 18 with family incomes up to 200% of poverty are free and can join the Basic Health Plan Plus. Because the BHP follows managed competition principles, plans bid prices for each age group, and enrollees pay more for picking plans with higher prices. The BHP bids the subsidized and non-subsidized program separately because of benefit differences and risk differences between the two populations. The full premiums for the non-subsidized program are somewhat higher than the full premiums for the subsidized program.

Because of very low enrollment above 125% of poverty, the BHP reduced premium cost sharing at the upper income range in 1995. This was effective at increasing enrollment in this range somewhat. In 1997, 71% of enrollment had incomes under 125% of poverty, 16% of enrollment was between 125% and 154%, 10% of enrollment was between 155% and 184%, and 3% of enrollment was between 185% and 200%. However, to reduce the cost of the BHP, the legislature

increased premiums effective January 1, 1998 (see Table 19). This increase will probably reverse eny progress the BHP has made in enrolling individuals at higher income levels. Base premiums also increased for the non-subsidized program. As a result, the BHP lost 15% of its non-subsidized enrollment at the start of 1998 and 5% of its subsidized enrollment.

Table 19: Family premium contributions for the Basic Health Plan (Source: Christenson, 1997)

INCOME (% FPL)	BEFORE 1/1/98	AFTER 1/1/98	LOWEST PLAN AGE 19-39 (1/1/98)
<66%	$10/mo	$10/mo	$10
66-100%	$10/mo	$12/mo	$10
100-125%	$10/mo	$15/mo	$15
125-140%	15%	24%	$23.87
140-155%	23%	33%	$32.82
155-170%	30%	40%	$39.78
170-185%	38%	49%	$48.73
185-200%	44%	59%	$58.68
>200%	100%	100%	$113.57

(4) Purchasing Vehicle

The Basic Health Plan purchases plans through the Washington Health Care Authority (HCA). The HCA also purchases for all state employees and many local public employees in Washington State. The bidding, pricing and accountability for the HMOs in the BHP is completely consolidated with the purchasing for public employees; however, the HCA prices the risk pools separately. In recent years the HCA has issued a joint RFP with Medicaid. Although the programs price their plans separately, the joint RFP facilitates standardized performance measures across the programs.

(5) Marketing

The BHP made its major marketing efforts in 1995 when the funding for the BHP was dramatically increased. From December 1995 to December 1996 the BHP grew from 84,000 lives to 195,000 lives. The main messages for their marketing were: (1) you can't afford to be without insurance; and (2) you can afford Basic Health (Christenson, 1997). By far the most effective way to get out their message was through health plans, providers, and local community-based organizations. The BHP has a very strong ally in the Friends of the Basic Health Plan, a group of consumer advocates and providers that helped to spread the word about the BHP when it had money for growth in 1995 and 1996. The BHP did some public service announcements and commercials but the stakeholder network is what paid off for them.

Another effective strategy for BHP was the use of a very simple "You Pay" tables which walked consumers through a few simple steps to determine exactly what it would cost their family to join a particular health plan. BHP accompanied the "You Pay" tables with a Consumer Guide which explained covered benefits and the health plan options. Together these documents helped people understand what they could get and what it would cost right away.

In 1995 and 1996, the BHP planned a major effort to market to employers. The plan was that employers could join the program and the low-income employees would receive subsidies just like individual enrollees. BHP planned to enroll 100,000 new members through employer groups. However, by the time their employer outreach contractor started to bring in membership, the BHP

was out of money and they needed to cap enrollment. It was much faster and easier to enroll individuals. The average employer size is about four people. There are very few groups that do not have at least one subsidized employee. Of the 5,486 covered lives from employers, 3,901 are either subsidized or children in the BHP+.

(6) Program Administration

The BHP processes applications by mail and determines eligibility in-house. The BHP staff does not determine eligibility for applicants on the waiting list for subsidized coverage until there is a space available. At that time, the BHP staff reviews proof of residency, the last 30 days of pay stubs, and last year's income tax return. BHP enrollees are supposed to notify the BHP when their income changes during the year so that BHP can change their premium cost sharing if appropriate. Once a person is determined eligible, BHP notifies the health plan and the health plan sends out a membership card. Health providers cannot distinguish BHP enrollees from any other group member. According to statute, the BHP is supposed to redetermine eligibility, however, they have not had adequate administrative staff to do this as regularly as they would like.

(7) Coordination with Employer-Based and Private Coverage

Originally, the BHP had a requirement that people could not be eligible if they had private coverage available with benefits at least as comprehensive as the BHP. This was extremely expensive and difficult to administer and this requirement was dropped. Currently, there is no check for whether enrollees have access to or are covered by private insurance. BHP staff reported that they have nowhere near the necessary resources at this time to check for private insurance coverage. There is also apparently very little concern that the BHP may be crowding out employer coverage. It is not a big issue in Washington.

There should probably be more concern that the BHP is crowding out individual coverage. Because the Washington Insurance Commissioner has regularly denied rate increases in the individual market, it is very difficult to buy individual coverage in Washington. As a result the BHP has probably been a dumping ground for high-risk individual market cases. They have experienced rapid growth in the non-subsidized BHP population.

The BHP also tries to reduce the gaps in coverage that people might experience as they move from BHP to private coverage. Usually when an individual disenrolls from the BHP, they are not permitted to reenroll for 12 months to discourage gaming by enrollees. However, if an individual leaves BHP for employer coverage and loses that coverage within 12 months, then that person can rejoin the BHP without going back on the waiting list.

(8) Coordination with Other Programs

The BHP closely coordinates coverage and purchasing with the Medicaid program. As discussed above, the BHP issues a common RFP with Medicaid. In addition, all subsidized children can join the BHP+ program and receive full Medicaid benefits. These children stay in the same health plans as their parents, but they do not pay premiums or service cost sharing. In addition, the BHP does not cover pregnancy care. For women up to 185% poverty, pregnancy care is delivered through the Medicaid First Step program. The women stay in their same health plan but they fill out a simple application form that permits the Department of Health and Human Services to verify their Medicaid eligibility. BHP refers between 700 and 800 women each year to the First Step program.

a) *Massachusetts:* Insurance Reimbursement Program (IRP)

The MassHealth program is among the four most ambitious state efforts to expand insurance coverage to low-income people (it ranks alongside the efforts in Minnesota, Washington, and Tennessee). This study is limited to a discussion of the IRP program, which is a subset of the broader MassHealth Program. Table 20 shows the coverage categories under the MassHealth 1115 waiver and the Massachusetts title XXI state plan. A central feature of the MassHealth 1115 waiver is that any eligible person[7] or family according to Table 20 is required to use the premium assistance payment approach and join an employer-based plan as an alternative to direct Mass Health coverage if:

- Purchasing such coverage is cost-effective for DMA;
- Such coverage meets or exceeds the Basic Benefit Level; and,
- the employer small or large contributes at least 50% to the monthly cost of that insurance.

Table 20: Eligibility, benefits and cost sharing in MassHealth and Massachusetts' Title XXI state plan by eligible population (Source: DMA, 1998)

<table>
<tr><th>ELIGIBLE POPULATION</th><th>BENEFIT FEATURE</th><th><100% FPL</th><th>100-133% FPL</th><th>133-150% FPL</th><th>150-200% FPL</th></tr>
<tr><td rowspan="5">Families with children</td><td>Eligible for direct coverage</td><td colspan="2">Family</td><td colspan="2">Children and pregnant women</td></tr>
<tr><td>Eligible for premium assistance</td><td colspan="4">Family</td></tr>
<tr><td>Eligible for wrap benefits</td><td colspan="2">Family</td><td colspan="2">Children and pregnant women</td></tr>
<tr><td>Inclusion in test for cost effectiveness</td><td colspan="2">All family members</td><td colspan="2">Children and pregnant women</td></tr>
<tr><td>Premium cost sharing</td><td colspan="3">None</td><td>$10/child/mo.; $30 max/family</td></tr>
<tr><td rowspan="5">Families without children</td><td>Eligible for direct coverage</td><td colspan="4">No</td></tr>
<tr><td>Eligible for premium assistance</td><td colspan="4">Family</td></tr>
<tr><td>Eligible for wrap benefits</td><td colspan="4">No</td></tr>
<tr><td>Inclusion in test for cost effectiveness</td><td colspan="4">No test</td></tr>
<tr><td>Premium cost sharing</td><td>None</td><td>5% of premium</td><td>10% of premium</td><td>15% of premium</td></tr>
</table>

[7] People with disabilities are an exception to the requirement for eligible persons to join employer-based coverage.

The IRP is limited to premium assistance payments for employees and their dependents, and employer subsidy payments made on behalf of small employer coverage. According to DMA's implementation plan (DMA, 1998), any of the premium assistance payments in Table 20 for small employer coverage will be paid from the MassHealth IRP Account. In addition, all Small Employer Insurance Partnership Program payments will come from the MassHealth IRP Account. Although this study is limited to the IRP, the MassHealth program requires the premium assistance approach, under the conditions described above, for both large and small employer coverage.

This study's qualitative and quantitative analysis of the IRP program is limited to the coverage that will be paid out of the MassHealth IRP Account.

(1) Target Population

The IRP is intended to decrease the number of uninsured employees of small businesses and their dependents. In particular, the IRP will subsidize a portion of the employee and the employer contributions to small employer coverage for families with income under 200% of poverty.

For families with children, DMA will buy family coverage when it is available at small or large employers, if it meets the minimum benefit requirements, if the employer contributes at least 50% of the premium and if it meets a cost effectiveness test. DMA compares what it would have cost under direct MassHealth coverage, for the family members who would be eligible for MassHealth coverage, to what it would cost for family coverage at an employer. Table 20 shows the types of family members who are included in the cost effectiveness test under different conditions. For children with families, the number of people included in the cost effectiveness test varies by family income. Because adults in families with children are not eligible for direct MassHealth coverage above 133% of poverty, such parents are only eligible through premium assistance at small employers. Because adults in childless families are only eligible for premium assistance, there is no cost effectiveness test.

(2) Benefit Package

The Division of Insurance will promulgate a regulation, subject to the approval of the DMA prior to the start of the IRP, that defines a minimum benefit package for premium assistance payments and for employer subsidies. The package will be comprehensive (although it is not yet been determined whether it will include prescription drug coverage), with typical deductibles, coinsurance, or copayments. DMA's goal is to exclude catastrophic plans but to include virtually all comprehensive small employer benefit plans.

As Table 20 shows, some groups are eligible for wrap around benefits through MassHealth that provide more comprehensive benefit coverage and lower cost sharing than virtually any employer-based plan. For families with children, the entire family is eligible for wrap benefits if it has income under 133% of FPL. For families with children with incomes above 133% of FPL, only pregnant women and children are eligible for wrap around benefits.

(3) Enrollee Premium Contributions

The Division of Medical Assistance has not yet established a final premium schedule for families with children and childless families. Table 20 shows the current proposed version of the premium schedule. For children with families there are no required premiums for employer-based coverage up to 150% of FPL. Above 150% of FPL the proposed premiums will be $10 per child, up to a maximum of $30 per family per month. For example, a family of two parents with one child would pay $10 per month for employer-based family coverage.

For childless families, there are no premiums under 100% of FPL. Above 100% of FPL, enrollee premiums range from 5% of total premium to 15% of total premium.

(4) Purchasing Vehicle

Premium assistance payments and employer subsidies are only available for coverage purchased through an employer. As discussed above, this study only reviews premium assistance payments for coverage with small employers. Premium assistance is not available to workers purchasing coverage in the non-group market.

(5) Marketing

DMA is currently developing its marketing approach for the IRP. Nearly every Massachusetts policy maker interviewed for this study identified the critical importance of marketing for the success of the IRP. DMA plans to work very closely with a small employer advisory committee to design a marketing strategy. Because insuring employees through the IRP depends on employers offering coverage, much of the DMA strategy will rely on marketing to employers. The employer outreach strategy will probably include developing strong outreach partnerships with professional associations, chambers of commerce, carriers, insurance brokers, and intermediaries.

In addition, the IRP and premium assistance in general, will benefit from the MassHealth marketing efforts. Community-based organizations, MassHealth providers, Uncompensated Care Pool providers, and other government agencies all distribute MassHealth applications when they come in contact with low-income families. If a family submits an application, and DMA determines that the family has access to coverage at a small employer, this information might be used to try to provide premium assistance to buy the employer coverage or to enroll the employer.

The partnership with the Department of Revenue (DOR) to identify likely eligible employees and employers is one of the most creative and potentially powerful outreach methods that DMA is planning. The Department of Revenue is committed according to DMA to analyze individual employee and employer tax information to assist in determining eligibility for premium assistance. By August 1998, DOR and DMA will mail letters to all taxpayers working in employers with fewer than 100 employees who appear to be eligible for the IRP based on their tax returns.[8] The letter will include a MassHealth application (necessary to be eligible for premium assistance payments) and a waiver for the employee to sign that permits DMA to inform the worker's employer that they are eligible for the employer subsidy for that worker. When DMA receives a waiver, it will then try to enroll the worker's employer in the program.

Although the enrollment and payment process for the IRP is complex, the use of DOR information greatly increases DMA's chance that most eligible workers and employers will hear about the program.

(6) Program Administration

DMA will administer the IRP in cooperation with a fiscal intermediary. In December 1997 DMA distributed a request for information from carriers, employers, and intermediaries concerning the best way to administer the program. DMA proposed a method for administering the program in its implementation plan submitted to the General Court on February 1, 1998. The following discussion is based on that report and interviews with DMA staff. The following discussion is a simplified version of DMA's implementation plan. For detailed information, readers should consult the implementation plan. This description is based on an employer enrolling in the program and

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[8] Employers are defined as small employers if they have 50 or fewer employees working 30 hours or more per week.

agreeing to modify payroll deductions for employees. If the small employer does not accept this responsibility, DMA is considering giving subsidies directly to enrollees.

- DMA distributes information and applications to potential enrollees and employers, processes applications from employees and employers, and determines eligibility.

- The contractor receives the employer applications and determines subsidy amount for employers. Employer subsidy is based on the number of employees under 200% of poverty (based on last years' income tax information) who accept insurance coverage at the small employer. Employer receives a monthly payment of $1/12^{th}$ the annual payment amount for each tier of health insurance coverage ($400 for individual, $800 for two-person, and $1,000 for family).

- DMA determines, through its computerized eligibility system, the subsidy for each employee at a small employer. First, the Division determines whether it is cost effective to buy employer-based coverage. It does this by first calculating an estimated payment amount for employer-based coverage. The estimated payment amount is the total premium for the family minus the employer contribution minus the family contribution from Table 20. DMA then calculates the cost effectiveness amount, which is what it would cost to insure the family members identified in Table 20 through direct coverage under MassHealth. If the estimated payment amount is less than the cost effectiveness amount, then the estimated payment amount is the actual amount DMA will pay for employer coverage. If the estimated payment amount is more than the cost effectiveness amount, then the family can choose whether to enroll in direct coverage or enroll in employer coverage and only receive the cost effectiveness amount from DMA.

- DMA informs the fiscal intermediary which employees are eligible and how much they should be paid each month.

- Each month (April 1), the contractor sends a voucher to the small employer identifying the total amount of subsidy the employer and employees will receive for coverage effective the next month (May 1). The contractor will also list how much each employee's payroll deduction should be reduced to account for his or her individual subsidy.

- Each month (April 1), the contractor will credit a holding account with each carrier with the total voucher amount for each employer.

- Each month (April 1), the carrier bills the employer for their total premium liability. The employer pays the carrier a cash payment plus the voucher.

- Each month the carrier reconciles the payment into the holding account by the state with their voucher from the employer. If they do not match, the carrier contacts the contractor to adjust the payment. Because DMA will only enroll new employees prospectively, virtually all changes in employee eligibility (such as leaving an employer) will cause the state to be overpaying carriers.

- By the end of each month (April 30), the contractor will perform on online match against carrier eligibility files to reconcile their employee and employer lists against the carriers' the lists. The contractor will adjust their payment for the next month

May 1, based on the new information in the carriers' employer and subscriber eligibility files.

- The contractor will change the next month's (May 1) voucher for employers and payments to carriers based on any overpayments from the previous month.

- The contractor and DMA will redetermine eligibility for the employers and the employees each year.

(7) Coordination with Employer-Based and Private Coverage

The premium assistance program was designed with careful consideration of the effect of government subsidies for health insurance on the private insurance market. MassHealth enrollees with access to employer-based coverage are required to accept that coverage if the employer contributes at least 50% to the premium and it is cost effective for MassHealth. The IRP provides subsidies to employers to discourage employers from dropping coverage because their employees can join government programs,. The theory is that the demand of non-subsidized employees for health insurance coverage in addition to the employer subsidy will discourage many employers from dropping coverage. To avoid gaps in coverage between employer and public coverage, and for fairness reasons, the premium assistance payments and the employer subsidy are available whether or not employers currently offer coverage. As a worker's income increases, they continue their employer-based coverage with a subsidy that decreases as family income increases.

However, the IRP cannot be used for coverage in the individual market. In addition, a large portion of the government funding for premium assistance and the employer subsidy will be spent on employers who already offer coverage and employees who already have coverage.

(8) Coordination with Other Programs

The IRP is closely coordinated with other MassHealth programs. From an administrative perspective, it is difficult to distinguish the IRP. All premium assistance payments (whether for large or small employers) will be managed through the same administrative process with carriers and employers. Family eligibility information for IRP premium assistance payments is maintained in the same eligibility system as for direct MassHealth coverage. Therefore, DMA should have good information systems support to help families manage transitions between programs.

DMA also plans to rely in part on Uncompensated Care Pool providers to distribute MassHealth applications. In this way uninsured workers who are using services who have access to employer based coverage will be informed that they can receive subsidies for employer coverage.

In some areas, DMA has placed a priority on distinguishing the IRP from other MassHealth programs. For example, DMA plans to directly pay carriers for employer and employee subsidies and to ask carriers to reconcile the employers' vouchers and actual payments from DMA. In developing this payment relationship with carriers, DMA is emphasizing that the IRP system, which will be administered by a private contractor, will be handled separately from other DMA carrier payments. Also, to make the IRP attractive to employers and low-income employees, it is important for DMA to make the program look as different as possible from welfare and Medicaid.

b) Oregon: Family Health Insurance Assistance Program (FHIAP)

The FHIAP was created in 1997 to remove economic barriers to health insurance coverage for low-income Oregon residents while encouraging individual responsibility, encouraging coverage of children, building on the private sector health plan system, and encouraging employer and employee

participation in employer sponsored health benefit plan coverage. FHIAP will pay subsidies to individuals to help them buy employer-based coverage or, if an enrollee does not have access to employer-based coverage, FHIAP will pay subsidies to certified non-group carriers on behalf of eligible individuals.

The program is budgeted $14 million for the two years beginning July 1, 1997. The state projects that it can serve between 13,500 to 15,000 people within this budget and expects to begin paying subsidies in July 1997.

(1) Target Population

The FHIAP program targets uninsured Oregonians with income under 200% of poverty. Initially, the state will limit enrollment to individuals with incomes under 170% of FPL. The state requires parents to cover all children in the family before an adult can receive a subsidy. To be eligible, persons must be uninsured at least six months prior to application.

Oregon's 1115 waiver covers all adults and children up to 100% of poverty and their Medicaid poverty level expansions cover pregnant women and children up to 133% of poverty. Families may choose to enroll in FHIAP instead of the more comprehensive Medicaid coverage.

(2) Benefit Package

FHIAP will subsidize any employer-based health benefit plan except for Medicare supplemental coverage, accident-only plans, specific disease or condition-only plans, and hospital-only plans. FHIAP will pay for any non-group benefit package from a certified individual carrier. In selecting individual carriers, FHIAP will require that the carrier offer at least one benefit plan that includes (as part of the plan or as an optional benefit): prescription drug coverage, preventive services, maternity benefits, mental health and chemical dependency, and hospice and palliative care (although an individual could certainly select a plan without any of these coverages). FHIAP will also make payments for medical savings accounts.

(3) Enrollee Premium Contributions

FHIAP will pay 95% of the enrollee share of employer-based coverage or 95% of the cost of individual coverage for families with incomes up to 125% of poverty. FHIAP will pay 90% for families with incomes between 126% and 150% of FPL. FHIAP will pay 70% for incomes between 151% and 170% of poverty.

(4) Purchasing Vehicle

There are three alternative purchasing vehicles:

- *Employer based coverage.* FHIAP applicants must use the subsidy to purchase employer-based coverage for the employee and dependents if the employer makes any contribution to employee or dependent coverage. To assist families manage their cash flow, FHIAP will pay subsidies directly to individuals prior to each month's payroll deduction. FHIAP will require monthly verification of each month's payroll deduction before paying for the next month.

- *Individual.* FHIAP will certify approximately six carriers to provide individual coverage for FHIAP applicants. Individuals may choose any benefit plan from the carrier. The FHIAP's contracted TPA will pay the carrier for each month's coverage, bill the family for their share (between 5 and 30% of the total premium), and bill the state for the subsidy amount.

- *Oregon Medical Insurance Pool (OMIP).* If a non-group carrier denies an FHIAP applicant under its medical underwriting standards, the applicant may enroll in Oregon's uninsurables pool. The FHIAP subsidy can be used to help purchase OMIP coverage.

(5) Marketing

The program is administered by the Insurance Pool Governing Board (IPGB) which has been responsible since the late 1980's for implementing a variety of initiatives to encourage employers to voluntarily provide coverage to their employees and their dependents. The IPGB will take two approaches for marketing the program:

- *Direct marketing and outreach.* IPGB staff will build on their current relationships with insurance agents, carriers, and communities to directly market the program. These activities are already underway and include:
  - Introducing more than 900 insurance agents to the program
  - Outreach to stakeholder groups
  - Involving outreach partners including Adult and Family Services branch offices, Community Action Programs, and rural health clinics.
  - Establishing working group of insurance agents to assist in employer marketing strategies
- *Agent Referral System.* IPGB will train insurance agents to provide assistance to program applicants requesting help with health benefit plan decisions. If they participate, agents will receive referrals from IPGB and the program's TPA when small employers or individuals need help choosing health insurance. Small group and individual insurance carriers will pay agents their usual commissions. To participate, agents will need to complete an FHIAP training program, and provide information on Oregon's Medicaid programs and the new title 21 children's program.

(6) Program Administration

The IPGP and its third party administrator will jointly administer the program. The eligibility and payment process will proceed as follows:

- The TPA will accept reservations for the program and maintain a waiting list of reservations.
- The IPGB will determine the monthly allocation of new subsidy funds for the FHIAP and will notify the TPA.
- The TPA will send applications to families on the reservation list. The applicant has 30 calendar days to return the application. The TPA has 15 calendar days to determine eligibility. The TPA will notify families if a family member might be eligible for Medicaid or the Children's Health Insurance Program.
- The TPA will notify applicants of eligibility and subsidy levels.

- For employer-based coverage the TPA will pay individuals prior to each month's payroll deduction but require monthly verification of the deduction before making the next month's payment. For individual coverage, the TPA will pay the carrier the full premium, collect from the individual, and bill the state for the subsidy.

- The TPA will manage the annual redetermination process and manage member terminations for premium non-payment, and other causes.

By avoiding any administration burdens on employers, Oregon believes it is achieving two goals: 1) reducing the chance that employers will reduce their contributions because they are aware that some of their employees are receiving subsidies from the state; 2) maintaining the privacy of income information for individual enrollees.

(7) Coordination with Employer-Based and Private Coverage

Oregon has designed their program to maintain continuity with private coverage and to support the private coverage system. To avoid the substitution of subsidized coverage for private coverage, applicants must not have had private coverage for six months prior to their application date (the TPA will verify this). To support the employer-based coverage system, FHIAP subsidies must be used for employer-based coverage if such coverage is available. To avoid gaps in coverage as families leave Medicaid, the IPGB will send information to all families losing Medicaid eligibility to inform them about the FHIAP. To support personal responsibility, families eligible for Medicaid coverage may choose to participate in FHIAP. Oregon does not require Medicaid eligible families to buy employer-based coverage when it is available.

(8) Coordination with Other Programs

As part of the FHIAP application process, the state plans to inform families about the state's Medicaid and children's programs. Insurance agents participating in the referral program will provide information about Medicaid and children's programs. As part of eligibility determination for FHIAP, the TPA will inform families of likely Medicaid eligibility for family members. Families are permitted to combine Medicaid, title 21, and FHIAP coverage, in any appropriate manner, to cover the entire family. To maintain continuity of coverage between Medicaid and FHIAP, the IPGB plans to select individual carriers for FHIAP who also serve Medicaid.

c) New York: Health Insurance Partnership Program (NYSHIPP)

NYSHIPP was created by the New York Health Care Reform Act of 1996 and budgeted $6 million per year for 1997 through 1999. It opened for enrollment on **X, X** 1997 and enrolled 598 businesses by January 1, 1998. Of these enrolled businesses, 388 were enrolled from an earlier program called the Regional Pilot Projects. The Regional Pilot Projects (RPP) began in 198**X** in the Albany region and Brooklyn with products offered by two carriers. The RPP had slightly different rules than NYSHIPP now follows and stopped accepting enrollment in June 1993 because of budget limitations.

(1) Target Population

NYSHIPP intends to assist sole proprietors without employees and eligible employers in purchasing small group health insurance policies for their full-time employees and dependents. Sole proprietors are only eligible if their gross household income is below 222% of the FPL. Officers, owners, directors, or others with a proprietary ownership interest in the small business are eligible, if

at least one employee is unrelated to them. Subsidized employees must work at least twenty hours per week.

The important feature of the NYSHIPP is that state subsidies are not limited to only low-income workers (except in the case of sole proprietors). The original RPP program only subsidized insurance for employees with incomes under 200% of the FPL. However, the state expects that it will not have adequate funding to subsidize all applicants. Employers with the lowest employee hourly wage will be approved first and the remainder will be approved as funding allows.

Based on a RAND study, New York estimates that there are approximately 285,000 employed individuals in New York State working in small businesses that do not have health insurance coverage.

(2) Benefit Package

Any comprehensive, community-rated small group product from any carrier qualifies for the program. There are no other benefits restrictions. All carriers operating in the small group market are required to participate in the program.

(3) Enrollee Premium Contributions

The state's contribution is limited to 45% of the total premium. Employee premium contributions may be no more than 10% of the total premium. Each employer must contribute at least 45% of total benefit cost and may pay all or none of the employee premium.

(4) Purchasing Vehicle

The purchaser for employer health insurance is the individual employer under the rules of New York's small employer market. Insurers are required to guarantee issue and community rate all insurance products for small employers. To compensate carriers for adverse risk selection, the state administers a risk adjustment pool.

(5) Marketing

NYSHIPP has budgeted $200,000 per year for an outreach coordinator. The contractor was selected in 1997 and is responsible for providing overall coordination and direction of the outreach and referral program. These functions include:

- developing and distributing the program brochure and application;
- designing and placing program advertisements;
- developing educational materials for small businesses on the importance of insurance, how to shop for and buy health insurance, and how to use it;
- developing materials to explain the program to insurers and holding regional meetings with insurers to explain and market the program;
- meeting with outreach partners to promote the program (associations of small businesses and insurance industry representatives, government agencies, media, and community-based organizations);
- maintaining a statewide phone hotline to provide information on the program and to prescreen applicants;
- referral of potentially eligible small businesses to health carriers;

- prescreening applicants (the New York State Department of Health performs final determinations);

The initial reports from the outreach contractor are that their phone volume has been tremendous.

(6) Program Administration

The New York State Department of Health administers the program with a subcontract for coordinating outreach and marketing. The eligibility determination and payments for the program are administered in the following way:

- The outreach contractor notifies small businesses and eligible insurers about the program;
- The outreach contractor pre-screens applicants who call into the hotline and mails applications to those requesting them. If necessary, the outreach contractor refers small employers to health carriers for coverage.
- The small business completes the application and returns it with the required documentation to DOH. Documentation includes:
  - a list of all employees (both those participating and those who are not participating) and their hourly wage;
  - a list of all officers, directors, and owners and their household income (whether or not they are participating);
  - a health benefits description form and contract price that must be completed by the carrier; and,
  - an affidavit that the business has not offered insurance to any employee within the last 12 months.
- Insurers are notified of the Employer's approval for the program with the following information:
  - The name of the business and its partnership certificate number
  - Each approved program enrollee with their contract type and price
  - The state's portion of the premium and the business' portion of the premium
  - The total 12 month certificate amount
- The business is mailed their partnership certificate with the following information:
  - The name of the insurer selected by the business
  - The partnership certificate number

- The business name and address
- The 12 month certificate amount

- The state pays its subsidy directly to the insurer and the insurer bills the small business only for the business' and enrollees' share of the premium.

- Employers are responsible for notifying the state within 60 days of any change in eligibility of an employee (such as reduction of hours below 20 per week) or any premium change for the employer. The state will reissue a certificate and reduce the monthly payment accordingly.

- The employer must reapply annually to establish eligibility for the program.

- The Department of Health will determine the continuing eligibility of participating employers before opening participation to new employers

(7) Coordination with Employer-Based and Private Coverage

The program is designed to only subsidize private market small group coverage. Employers are ineligible if they have offered coverage within the last year.

(8) Coordination with Other Programs

The state does not coordinate NYSHIPP coverage with any other programs.